The Reorganisation of The National Health Service, 1965-74.

Thesis

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The Reorganisation of The National Health Service, 1965-74

by

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Abstract

This is a case study of the development of plans for an administrative reorganisation and the part played in that process by interest groups and government departments. It is argued that changes in the context in which the NHS operated in terms of demography, epidemiology, social philosophy and administrative concepts as well as problems of cost and co-ordination had made adjustments to its structure desirable, and that proposed changes in the structure of local government and its social services crystallised this need. The separation of medical and social work skills in the field by the implementation of the Seebohm Report made a fundamental review of the NHS structure necessary as it involved a shift in cost burdens from local to central government which invited questions concerning administrative supervision from the centre and political questions concerning the future of the medical officers of health.

It is argued that the reorganisation involved questions of both vertical control and lateral co-ordination. The former was determined by the desire of the Treasury for a greater degree of management accountability and of the Central Department for improved control and implementation of policy decisions, which meant that few concessions were made to interest groups which might hinder the attainment of these objectives. Interest groups were more influential in determining the character of proposals concerned with lateral co-ordination, and here the pattern indicated by Willcocks in his study of the creation of the NHS is found

to be repeated, with groups commanding resources based on technical expertise (the medical profession) found in varying degrees to be more influential than those commanding administrative expertise (local government).

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Abbreviations

The following abbreviations have been used in this thesis.

AHA	Area Health Authority
AHA(T)	Area Health Authority (Teaching)
AMC	Association of Municipal Councils
BMA	British Medical Association
BMJ	British Medical Journal
CCA	County Councils' Association
CCHMS	Central Committee for Hospital Medical Services
CPC	Conservative Political Centre
DEA	Department of Economic Affairs
DES	Department of Education and Science
DHSS	Department of Health and Social Security
DMT	District Management Team
DNA	Deoxyribonucleic Acid
GMSC	General Medical Services Committee
GNP	Gross National Product
HMC	Hospital Management Committee
JCC	Joint Consultative Committee
MRC	Medical Research Council
NHS	National Health Service
PAR	Programme Analysis Review
PESC	Public Expenditure Survey Committee
R and D	Research and Development
RHB	Regional Hospital Board
RNA	Ribonucleic Acid
SHHD	Scottish Home and Health Department
SRM	Special Representative Meeting

Chronology

November	1946	National Health Service Act passed
July	1948	National Health Service commenced
January	1956	Guillebaud Report on the Cost of the National Health Service published
May	1957	Report of the Percy Commission on the Law Relating to Mental Illness and Mental Deficiency published
February	1959	Report of the Cranbrook Committee on Maternity Services published
October	1959	Plowden Committee on the Control of Public Expenditure established
July	1960	Enoch Powell becomes Minister of Health
July	1961	Plowden Report published
January	1962	A Hospital Plan for England and Wales (Cmnd 1604) published
October	1962	Porritt Report published
October	1963	Annie Gillie Report on the Field of Work of the Family Doctor published
October	1964	Kenneth Robinson becomes Minister of Health
July	1965	Robinson establishes his personal long-term study group on inter-face between health and social services
December	1965	Seebohm Committee on Local Authority Personal Social Services established
February	1966	Fulton Committee on the Civil Service established
May	1966	Redcliffe-Maud Commission on the Reform of Local Government established
February	1967	Ministry of Health establishes long-term planning unit
November	1967	Robinson announces internal inquiry into re-organisation of the National Health Service
April	1968	Richard Crossman assumes overall responsibility for health and social services
June	1968	Fulton Report published

July	1968	Seebohm Report published
July	1968	Green Paper I on NHS published
November	1968	Department of Health and Social Security established with Crossman as Secretary of State
May	1969	Redcliffe-Maud Report on Reform of Local Government published
February	1970	Green Paper II on NHS published
February	1970	Labour's White Paper on Local Government Reform published (Cmnd 4276)
May	1970	Local Authority Social Services Act passed
June	1970	Sir Keith Joseph becomes Secretary of State
November	1970	Joseph announces his intention to re-organise the National Health Service outside local government
February	1971	Conservative White Paper on Local Government Reform published (Cmnd 4584)
April	1971	Local Authority Social Services Act implemented
May	1971	Consultative Document on Re-organisation of the National Health Service published
June	1972	Report of the Review Team on the Department of Health and Social Security presented
August	1972	White Paper on Re-organisation of the National Health Service published (Cmnd 5055)
September	1972	Management Arrangements for the Re-organised National Health Service published (Grey Book)
October	1972	Local Government Reform Act passed
November	1972	National Health Service Re-organisation Bill introduced in the House of Lords
February	1973	National Health Service Re-organisation Bill introduced in the House of Commons
July	1973	National Health Service Re-organisation Bill passed
April	1974	Local Government Reform Act and National Health Service Re-organisation Act implemented

CHAPTER I

INTRODUCTION

February, 1967 was a very significant month not only for the re-organisation of the National Health Service, but for other structural reforms under consideration in local authority social services and the local government structure itself. During the course of this month, the Seebohm Committee considering the re-organisation of local authority social services felt sufficiently advanced in its thinking to meet the Royal Commission on Local Government to inform it of the likely trend of its proposals. About the same time, certain members of the Seebohm Committee met privately with the Minister of Health, Mr. Kenneth Robinson, and told him personally of the direction in which the weight of the evidence the Seebohm Committee had received was leading its thinking, and of its implications for Medical Officers of Health and the Public Health sector. It was felt that he might wish to consider if steps were necessary to counter possible demoralisation in the Public Health Service as the Seebohm Committee's proposals became known. Shortly after this, the Minister informed his long-term study group that an internal investigation into the possibility of re-organising the National Health Service had been established.

Given the internal nature ofthe enquiry, and the clear advantages of the reform of these three structures being undertaken in a co-ordinated way so that the principle of community care which had been established over the previous decade might become a reality, and given also the current interest of the Treasury in management questions, it might be thought that the re-organisation of these three

structures would be centred in one place, and that the Treasury would have successfully pressed for a National Health Service structure that would enable the costs of morbidity to have been more successfully controlled than in the past. Partially, this is true, but in practice, the reform of the three structures had quite separate origins, and were only co-ordinated, in so far as they were, at the end of the process. Equally, influential as the Treasury was, particularly in precluding some possible solutions, the Ministry of Health, and subsequently the Department of Health and Social Security, had its own priorities, whilst the British Medical Association and the Teaching Hospitals were also able to exert considerable, if negative, influence, and the local authority associations also had some success when the debate reached the parliamentary forum. The re-organisation of the NHS demonstrates that decisions about change in administrative structures in public services are not necessarily centred in one location, but may be subject to the perceptions not only of government departments but of other interested parties, particularly those which control resources involved, such as expertise in the case of the British Medical Association.

By February 1967, it was already the case that a number of different interests would be involved in the re-organisation of the National Health Service, and that each of these would view the situation in different ways. The Ministry of Health was concerned to obtain greater co-ordination between the three branches of the National Health Services, not only to improve service to the consumer, but to enable it to implement strategic decisions on policy

with a greater degree of effectiveness. The Treasury saw re-organisation as an opportunity to ensure value for money within the National Health Service, and to establish a strong vertical line of management accountability which would help to cut down unnecessary expense and reduce the costs of morbidity. The British Medical Association, which had already gone some way down the road to committing itself to a re-organisation of the National Health Service by the publication of the Porritt Report in 1962, saw a necessity to ensure that the profession remained out of the control of local government, that the independence of the profession, particularly that of general practitioners, remained, and that doctors should play a significant role in management. Other elements in the medical professions had their own perceptions, notably the teaching hospitals who sought to protect their privileged position, and the medical officers of health, who were faced with the necessity to define a new role for themselves. The local authority associations perceived the re-organisation as a means of securing the return of a service whose loss had been felt keenly since 1946, or at least as a means of securing some degree of participation in the new structure. Not least, there were the different perceptions of the various ministers who were involved during the long course of re-organisation. All these interests were to play a significant part in shaping the new administrative structure of the National Health Service through the various channels available to them. Their perceptions and techniques will be the subject of later chapters.

By February, 1967, an accumulation of factors had

already made some re-organisation of the National Health Service likely, and the Seebohm Committee was really the final element which signalled the beginning of the process. The rising cost of the National Health Service had caused alarm from its inception, whilst a number of surveys had indicated the inadequacy of co-ordination between the elements in the tripartite structure. A succession of reports had seen the evolution of the concept of community care which required co-ordination of the health and social welfare services, and the proposed reform of the local government structure and local authority social service provision meant that some change in the National Health Service structure would be inevitable if this co-ordination was to be achieved. Changes in medical technology and epidemiology had also altered the balance required between acute and chronic medicine, and between hospital and community care. In particular, mental health and geriatrics required greater provision whilst the old public health functions such as those relating to infectious diseases were no longer of the same significance as previously.

The aim of the thesis is, therefore, to demonstrate that in the determination of the structure of the re-organised NHS the desire of the Central Government, particularly the Treasury, to establish a stronger line of vertical control over the NHS, was more important than the claims of lateral co-ordination. This is the theme of Chapters IV and V. This desire for stronger central control has to be viewed against the development of concepts relating to management and administrative change in central government and the prevalent view in central government that the Ministry of

Health had an unsatisfactory management relationship with the NHS. Thus, central government interests were focussed on the Ministry of Health in the era of Fulton reforms. This is discussed in Chapter III, Section (A).

The possibilities relating to lateral co-ordination were to some extent limited by the implementation of the Seebohm Report and by the nature of local government reform. The implication of the Seebohm Report that local authority health services might be moved into the NHS compelled the Ministry of Health to re-consider its vertical position above the NHS, whilst the debate on local government reform offered no real opportunity for control at a regional level. These factors are examined in Chapter III, Sections (B) and (C).

Another limiting factor in connection with lateral co-ordination was the nature of the groups involved in the operation of any scheme of co-ordination, namely the British Medical Association and the Local Authority Associations. The positions of these bodies in relation to the administration of the NHS were basically already well known to the Central Department and it was unlikely that there would be much flexibility or room for manoeuvre available to make a satisfactory accommodation between them easy or likely. These positions are indicated in Chapters V and VI.

Behind all these aspects of the re-organisation of the NHS lie changes in epidemiology and medical technology which shifted the emphasis in relation to the importance of different diseases and treatments and which were associated with developments in social doctrine concerning the importance of community care. Both of these factors were

significant in causing a re-appraisal of the NHS structure and in suggesting to central government that for an appropriate re-allocation of resources to take place, particularly from the acute to the chronic sector of medicine, stronger central management of the NHS was essential. This is the theme of Chapter II.

The methodology employed has been first, to obtain basic data from published sources in central government, local government and the BMA. Secondly, this has been supplemented by interviews and discussions with some of those involved in the events[1]. Thirdly, access has been given to some unpublished data of a confidential nature. Where possible, data has been checked by cross-reference between sources. There are limitations inherent in this methodology. Clearly, sources such as published minutes often conceal as much as they reveal, and attempts have to be made to read between the lines. Interviews can be helpful here, but not all sources have been prepared to assist in this way, and in drawing upon published data to establish a framework for interviews, it is possible to place an interpretation upon the material which may give an incorrect or unhelpful slant to the discussion, so that it may become difficult for a more accurate picture to emerge. An attempt was made initially to conduct structured interviews, but this was abandoned as it was found that the interviewee often approached the subject from a different perspective or with a different emphasis from that anticipated. Instead, a list of questions was prepared to

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[1] Ten interviews were conducted, including three with former Ministers, three with local government participants and four with those with academic and related interests.

act as a guide for the interview, but the interviews themselves were not formally structured. Thus, judgement may be biased in spite of efforts to check data and judgements by cross-references. Again, some information has been derived from single sources and here checking procedures have not been possible[1]. In other cases, information has been supplied by sources which must remain anonymous and no attribution is possible at this time.

In concluding this introduction it may be useful briefly to indicate some of the wider context from which the concepts of vertical and lateral structures are drawn.

An understanding of the concepts of vertical and lateral structures must take into account the differential distribution of power between positions in the structures and between the occupants of those positions. Power is the essence of organisation, but the concept of power itself gives rise to problems of definition which have been discussed by many writers. However, for the purpose of examining power in work organisations, power may be regarded as the capacity to use resources to affect others.[2]

Two structural fundamentals of organisation are bound up with power in organisations, hierarchy (vertical control) and division of labour (lateral integration), although the two concepts overlap as hierarchy is partly division of labour, as the tasks of administrative superiors differ from those of

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[1] Unfortunately, the B.M.A. declined to provide an interview.

[2] Hickson, D.J. and McCullough, A.E., Power in Organisations in Structure and system: basic concepts and theories, p. 11, Milton Keynes, Open University Press, 1974.

their subordinates. There are, of course, many different types of hierarchy ranging from those with a single top position to groups who come together without naming any final authority[1]. In the case of governmental organisations the formal decision-making authority is often comparatively centralised for reasons of public accountability. Nevertheless, organisations which employ substantial proportions of highly trained professional personnel tend to have a less hierarchical power distribution than is common in organisations in industry, commerce or governmental bodies[2]. This may help to account for the difficulties encountered in re-organising the National Health Service, where the professional organisation of the doctors may offset to some extent the governmental pressures for centralisation.

The concept of structure itself has a long history in sociological theory and interested both Durkheim and Weber.[3] At its widest, organisational structure refers to the observed, patterned continuity in the behaviour and activities of organisational members over time, although formal structure, with which the re-organisation of the National Health Service was largely concerned, is a much narrower concept. In addition to the existence of regularities in the behaviour of members of the organisation, the notion of structure involves, at least implicitly, some reference

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[1] Ibid., p. 12

[2] Pugh, D. S. and Hickson, D. J., The Comparative Study of Organisations in Salaman, G. and Thompson, K. (eds.), People and Organisations, pp. 50-66, London, Longmans, 1973.

[3] Durkheim, E., The Rules of Sociological Method, New York, The Free Press, 1938, p. 3.

Weber, M., The Theory of Social and Economic Organisation, Oxford University Press, 1947.

to the ways in which these regularities are achieved. Thus, structure may be viewed as emerging from ongoing interactions and negotiations or from imposition and constraint, or a combination of both[1]. In the case of the re-organisation of the National Health Service, arguably the Central Department tended towards imposition and constraint in its attempt to achieve the kind of vertical control it required, e.g. by determining the composition of regional authorities, but engaged extensively in negotiations with regard to lateral organisation (e.g. through the Working Party on Collaboration).

Many attempts have been made to establish bases for the classification of organisations, e.g. by Weber, Woodward and Perrow[2]. Developments in this field have given rise to what has become known as 'contingency theory'. This rests upon the assumption that organisational characteristics have to be shaped to meet organisational circumstances, and the extent to which any organisation secures a 'goodness of fit' between situational circumstances and structural characteristics will determine the level of organisational performance[3]. However, it is by no means always clear exactly what the

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1 Salaman, G., Classification of Organisations in Structure and system: basic concepts and theories, Milton Keynes, Open University Press, 1974, p.40

2 Weber, M., op. cit.

Woodward, J., Management and Technology in Burns, T. (ed.), Industrial Man, Harmondsworth, Penguin, pp. 196-231, 1969.

Perrow, C., A Framework for the Comparative Analysis of Complex Organisations in Brinerhoff, M.B., and Kunz, P.R. (eds.), Complex Organisations and Their Environments, Dubuque, Iowa, William C. Brown, 1972, pp. 48-67.

3 Greenwood, R., Hinings, C.R. and Ranson, S., Contingency Theory and the Organisation of Local Authorities. Part I: Differentiation and Integration, Public Administration, Spring, 1975, pp. 1 - 23.

goals of the organisation may be or how far they can be identified with the goals of the members making up the organisation. The goal of the National Health Service might be, for example, the improvement of the health of the people, whereas the goal of the General Practitioners might be the maintenance of their independent contractual status regardless of the possible effects of this on lateral co-ordination to improve the delivery of services to patients.

One important distinction which has been introduced into the study of organisations is that between open and closed systems, the significance of which is that it involves the realisation that the structure of an organisation may be affected by external factors, a fundamental departure from the tradition of endorsing or prescribing an ideal, universal type of organisation[1]. A number of studies have been made which endeavour to identify relevant situational variables and to test them empirically. The variables involved have included size, technology and environment. The Aston Programme is one example of an attempt to explore relationships between structural features (structuring of activities and concentration of authority) and characteristics of the varied contexts in which structures appear (size, dependence on other organisations, technology, purpose, ownership, location and origin)[2].

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[1] Elliott, D., The Organisation as a System in Structure and system: basic concepts and theories, Milton Keynes, Open University Press, 1974, pp. 81-91.

[2] Pugh, D. S. and Hickson, D. J., Organisational Structure In Its Context: The Aston Prgramme I, Farnborough, Saxon House, 1976.

One of the most relevant studies carried out recently has been that by Greenwood et al. who have examined contingency theory and the organisation of local government authorities using the complementary concepts of 'differentiation' and 'integration'. By 'differentiation' is meant the division of labour within the local authority, expressed as the number of organisational parts, whilst 'integration' refers to those devices intended to counter-balance the division of labour. The writers examined the possibility of an empirical link between the structural arrangements of the new local authorities and their size (i.e. geographical extent; population served; number of employees) and their environment (such variables as population density, socio-economic structure, wealth etc. rather than the more common definition in organisational sociology where it refers to the amount of uncertainty facing the organisation). Further sets of contingencies were added, namely the inter-dependence of local authorities, the politics of the local authority and the notion of ideas or ideology concerning such concepts as corporate planning and administrative efficiency[1].

The findings of Greenwood et al. on size and functional diversity followed those of Pugh et al.[2], Blau and Schoenherr[3], Burns and Stalker[4] and Lawrence and Lorsch[5].

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1 Greenwood, R. et al., op. cit., Public Administration, Spring, 1975.

2 Pugh, D.S., The Context of Organisational Structures, Administrative Science Quarterly, March, 1969, pp. 91-114.

3 Blau, P. and Schoenherr, R., The Structure of Organisations, New York, Basic Books, 1971.

4 Burns, T. and Stalker, G.M., The Management of Innovation, London, Tavistock, 1961.

5 Lawrence, P.A. and Lorsch, J., Organisation and Environment, Harvard University Press, 1967.

It is suggested that large organisations cope with the problems of scale initially through differentiation, which in turn creates further problems and gives rise to the development of internal structures to cope with issues of co-ordination and control. This is true also for organisations which face complex environments and which provide a wide range of products and services. Support is provided also for ideology as an important variable, as had been argued previously by Chandler[1] in relation to management styles in determining changes in industry and by Selznick[2] in relation to the use of ideologies to justify organisational forms and the production of particular administrative frameworks. The importance of political and interactive processes within organisations, i.e. the structure of group interactions, is also stressed. As Child puts it:

> "the political process in organisations therefore incorporates an important normative aspect, and it is the means through which the values of various groups impinge to a greater or less degree upon organisational decisions. This process operates in regard to the interface between situational factors and the structure of organisations because political criteria are brought to bear on the way in which contingencies are interpreted"3.

Greenwood et al. conclude that

> "a necessary component of any theory therefore must be the structure of group relations, the patterns of interest, expectations and belief which mould the

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1 Chandler, A., Strategy and Structure, Massachusetts Institute of Technology, 1962.

2 Selznick, P., T.V.A. and the Grassroots, Berkeley, University of California Press, 1952.

Selznick, P., The Organisational Weapon, New York, McGraw Hill, 1952.

Selznick, P., Leadership in Administration, New York, Harper and Row, 1957.

3 Child, J., Organisation Structure, Encironment and Performance: the Role of Strategic Choice, Sociology, vol. 6., 1972.

"design and operation of organisational structures"[1].

In relation to the structure of the National Health Service it may be suggested that, at the outset, the problems of establishing such a large organisation, providing a wide range of services, were met by differentiation, i.e. by establishing the tripartite structure. Longitudinally, some of the variables indicated by such writers as Pugh et al. and Greenwood et al. come into play and revealed the problems of co-ordination and control. The variables which were first, size, in relation to numbers of people treated and increasing costs. Second, there was the environment which changed in terms of demography (age and ethnic structures of the population) and epidemiology (from the diseases of malnutrition to those of affluence and from acute to chronic conditions). Third, advances in medical technology altered the range of possibilities available and raised issues of resource allocation (e.g. provision of renal dialysis). Fourth, there were changes in the interdependence of the National Health Service not only between the different parts of the structure but between the National Health Service and other agencies (e.g. local government over the provision of complementary social services following the Seebohm Report). Fifth, there was the growth of ideologies concerning management style, corporate management, administrative efficiency and democracy in the National Health Service (the cause espoused during re-organisation by the Local Authority

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[1] Hinings, C.R., Greenwood, R., and Ranson, S., Contingency Theory and the Organisation of Local Authorities: Part II. Contingencies and Structures, Public Administration, Autumn, 1975, pp. 169-190.

Associations and, latterly, the Labour Party). Finally, there were the group interactions and patterns of interests, expectations and beliefs which were involved such as the desire of the medical profession for independence from local government as reflected in their contractual arrangements, the expectations of professional independence on the part of such groups as social workers, and the belief of local government that it could provide the democratic framework for the administration of the National Health Service.

CHAPTER II

The Setting: Social Doctrine and Medical Technology

When it was established in 1948 the NHS had planned objectives over and above that of free and universal provision of medical services. It aimed also to achieve a more even geographical distribution of hospitals and doctors and to rationalise the voluntary and local authority hospital systems. In order to achieve these objectives, general practitioners were given a form of distributive machinery, and the hospitals were taken into ownership. However, this was to give rise to the problem of whose ownership. In a sense, this is the problem that was to lead ultimately to the re-organisation of the NHS in 1974. The local authorities were not considered appropriate in 1948 because they were not acceptable to the medical profession and because this would have offended the trustees of voluntary hospitals. Local authority areas were also considered inappropriate for hospital administration because of the borough/county (town/country) division, and because the areas were too small for planning a comprehensive hospital service. Joint authorities were dismissed as unworkable, so a new structure was set up with 14 Planning Regions (Regional Hospital Boards) and 350 operational Hospital Management Committees.[1]

The structure established for the NHS was a tripartite one, consisting of the Hospital Service, Local Authority Health Services, and Executive Councils for the independent General Practitioner sector. Clearly, problems of co-ordination were likely to arise between these three branches, and

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[1] A.J. Willcocks, The Creation of the National Health Service Routledge and Kegan Paul, London, 1967, pp 95 - 100

the mounting cost of the NHS was to enable critics to point to the administrative structure as one reason for the financial problems. In 1956, therefore, the Guillebaud Report looked at the general situation, and stressed the need for better co-ordination for the aged, obstetrics and mental health. It stated:

> "It seems to us that if the National Health Service is to work properly, co-ordination is needed at three levels - first, centrally, so as to ensure that all three branches of the Service are associated together in carrying out a single national policy; secondly, at the level where the national policies are applied to local circumstances; and thirdly, at the personal level where individual workers in the Service must co-operate to help a particular patient".[1]

However, the Report also said:

> "We believe that the structure of the National Health Service laid down in the Acts of 1946 and 1947 was framed broadly on sound lines"[2], and "We are strongly of the opinion that it would be altogether premature at the present time to propose any fundamental change in the structure of the National Health Service".[3]

This was followed by a number of special inquiries. Cranbrook (1959) on the Maternity Service was tempted to say that the service could not be managed on a tripartite structure, but only recommended better co-ordination.

> "While integration is a desirable aim the National Health Service is as yet young and as experience accumulates it might develop towards a unified service in ways which cannot be foreseen at present. We consider, however, that the spontaneous co-operation here and there on the part of those engaged in the health services has already brought the three branches closer together

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[1] Report of the Committee of Enquiry into the Cost of the National Health Service, Cmnd 9663, 1956, para. 735, p. 267

[2] Ibid, para. 147, p. 62

[3] Ibid, para. 148, p. 62

and might well pioneer the natural evolution of a unified service.

We consider that with a tripartite service, co-ordination is required at the administrative and executive levels. The first, at administrative level, to ensure that three independent comprehensive services are not built up and to see that each part knows its own sphere so that no particular function is left neglected. The second, at executive level, to ensure that each member is aware of his duties and that they interlock with those of the other members. As has been shown, most of the complaints appear to be due to lack of co-ordination between the officers and might well occur whether the service was unified or in two or three sections.

In order to better the present administration, measures need to be taken to improve the co-operation and co-ordination of the three branches of the service".[1]

The Royal Commission on the Law Relating to Mental Illness and Mental Deficiency and the subsequent Mental Health Act (1959) were crucial as they pressed for more community care in the field of mental health. The following quotations may serve to illustrate the point.

"The recommendations of our witnesses were generally in favour of a shift of emphasis from hospital care to community care".[2]

"We have felt it right to assume that a fair share of our national resources will be allocated in future to the mental health services both by the central government and by local authorities and that it is recognised that in many areas these services have a considerable amount of leeway to make up compared with some other parts of the country's health and welfare services".[3]

"In the preceding section of this chapter we have often mentioned the need for local authority and hospital staff to work in close contact with each other so as to ensure continuity in the care of

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[1] Report of the Maternity Services Committee (Cranbrook, Ch.) (1959), paras. 297 - 9, p.83

[2] Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, (Percy, Ch.) Cmnd 169, (1957) para. 601, p.207

[3] Ibid., para. 609, p.210

> individual patients and to make the best use of the staff and other resources of each branch of our health and welfare services. This is especially important in connection with social work for out-patients and for patients discharged from hospital".[1]
>
> "We place considerable importance on the members of the hospital and local authorities getting to know each other's services".[2]
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> "Arrangements for close co-operation between the local authorities and the hospitals should be made on the initiative of the authorities in each locality, and should cover the planning of new services as well as co-operation over existing services. It is also desirable that schemes of co-ordination which have been found successful in any locality should become widely known. It might be useful if the Ministry of Health were to help to disseminate information about such schemes".[3]
>
> "In relation to mental health it seems to us very difficult to draw a distinction between community services needed on medical grounds and those needed on social grounds".[4]

As a result, mental health developed as a real growth sector in the NHS, and the tripartite structure presented a real problem for these developments, for example in demarcation and co-ordination between local authorities and hospitals.

The Porritt Report[5] was also a significant development in the move towards a more unified NHS, and came at a critical time in government/profession relations. It argued for one unified unit of administration, area health boards, with boundaries designed to meet the needs of community medical care in its widest sense, including all medical and

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[1] Ibid., para. 690, p. 233

[2] Ibid., para. 691, p. 234

[3] Ibid, para. 693, p. 234

[4] Ibid., para. 706, p. 238

[5] Medical Services Review Committee, A Review of the Medical Services in Great Britain: Report, Social Assay, 1962.

ancillary services. The area health boards were to have responsibility for overall planning and development, and for the administration of all services, with subsidiary councils responsible to the area health boards for the day-to-day administration of individual services. The Chief Officer of the area health board would be medically qualified, and all professions involved in the service were to be represented on the boards. The family doctor, hospital, preventive, personal and school health services would be transferred to area health boards, as would the ambulance service. Liaison with teaching hospitals would be provided by cross-representation. Co-ordination would be provided through a Department of Social Health based on the principal hospital in the area under a consultant in social health who might be drawn from the ranks of existing medical officers of health. It was also pointed out that recent changes in medicine demanded a new outlook on medical education. There should be greater emphasis on social, community and environmental medicine. This point was subsequently taken up by the Todd Commission on Medical Education.

The Porritt Report was never adopted as policy by the BMA, and was certainly never accepted by its General Medical Services Committee. Nevertheless, its importance was two-fold. First, as Kenneth Robinson pointed out, it thawed the post-Guillebaud freeze on discussion of the NHS structure.[1] Second, the committee was made up of highly

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[1] K. Robinson, Partnership in Medical Care, Ninth Maurice Bloch Lecture, University of Glasgow, 1968.

influential medical people drawn from, though not representative of, the leading Royal Colleges and other important medical bodies.[1] This made the Report politically important, because it later made it difficult for the medical profession to argue subsequently against unification.

The Royal Commission on Medical Education was also to contribute to the move towards the development of the social doctrine of community care. In fact, two elements were important in the Todd Commission's Report.[2] First, there is the recognition of the need for the medical student to be educated in community medicine.

> "In our view, undergraduate medical education should include some study of this field. Students should be acquainted with the means of providing health services for the whole population, and with the related social and economic problems; this involves an appreciation of the epidemiology of disease and of the contributions that are made by the hospital, general practitioner, local authority and other services".[3]

> "A separate but related development is the need for the doctor to work in close co-operation, both in diagnosis and in therapy, with people who are not medically qualified..... The leadership which the doctor often has to exercise has sometimes in the past appeared to be based on the assumption of a charismatic authority which has already ceased to be convincing and in the future will be completely inappropriate. The basis of the doctor's leadership will be his superior knowledge of the central facts of the clinical situation, his ability to exercise a decisive influence on the patient's illness, and his capacity to guide and co-ordinate the work of others whose co-operation is essential".[4]

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[1] Royal College of Physicians, Royal College of Surgeons, Royal College of Obstetricians and Gynaecologists, Royal College of Physicians of Edinburgh, Royal College of Surgeons of Edinburgh, Royal Faculty of Physicians and Surgeons of Glasgow, Society of Medical Officers of Health, College of General Practitioners, and the BMA.

[2] Report of the Royal Commission on Medical Education, (Todd, Ch.), Cmnd 3569, 1968.

[3] Ibid., para. 280, p. 115

[4] Ibid., para. 29, p. 30.

The second important element is the emphasis placed on future manpower requirements in terms of the output of medical graduates, a line of thought very much in tune with developments taking place in central government planning, and the Todd Report devoted a complete chapter to the exercise. In fact, the Royal Commission decided early in its inquiry that "a substantial increase in output of medical graduates was required without delay". In June, 1966, it recommended to the Government that steps should be taken to expand existing medical schools and to establish new ones. As a result, the Government decided to bring forward the re-development of the medical school at Leeds and the opening of the new medical school at Southampton. However, the Report still suggested that there would be an accumulated deficit of 10,000 medical graduates by 1976. It pointed out that the number of doctors per million of population had been rising in all advanced countries in the twentieth century and that Britain lagged behind Belgium, West Germany, Australia and the United States in this respect. The Report estimated that the number of doctors required in Britain in 1995 would be 119,800 compared with 62,700 in 1965, and that 4,550 medical graduates would be needed each year in the 1990s which would be almost double the estimated number of graduates in 1975.[1] This clearly had implications not only for medical education but for the necessity to make the most economic and effective use of resources of medical and related manpower.

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[1] Ibid., pp. 127 - 147

Another line of development which was also to increase the trend towards community care came from the Hospital Plan of 1962.[1] The Ministry of Health had set a target figure of 3.3 acute beds per 1,000 population although other estimates suggested that 4½ - 5 was more realistic.[2] The new concept of "Best Buy" Hospitals established a figure of 2 acute beds per 1,000 population, using a more sophisticated view of beds required. The number was seen to depend on the complementary health and welfare services available outside, and it was essential therefore, to plan these together in the provision of new hospitals, as proper services were needed if doctors were to be persuaded to discharge patients earlier, and a 7 - 10 year planning period was necessary in the provision of a new hospital. As the Minister of Health, Mr. Enoch Powell, put it in the debate on the Hospital Plan:

> "Important though this plan is, it is only part of a greater whole, to which it belongs and in which it must be firmly set. On the day - and this was no accident - on which this plan was published, I asked all the local health and welfare authorities to prepare their own ten-year plans for the development of their own health and welfare services for community care. Those plans will be coming in during the latter part of this year and will find their place in a plan for the development of community care which will be the counterpart, and I believe the worthy counterpart, of this Hospital Plan.
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> "It may have been noticed that no less than one quarter of the text of this plan is devoted to community care, to care outside the hospital. That is right, because the provision which is made inside the hospital is complementary to that made outside. The principle upon which we approach this is that the prevention of illness

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[1] Ministry of Health, A Hospital Plan for England and Wales, Cmnd 1604, (1962)

[2] B. Abel-Smith, "Why Integrate?", lecture given at the London School of Hygiene and Tropical Medicine, 4 February, 1974.

and the care of illness should take place in the community, except where the specialised services of the hospital are necessary".[1]

One aspect of this development was that Home Care became increasingly centred around general practitioners with, for example, the attachment of health visitors. This was accompanied by a growth in the development of health centres.[2] The position of the general practitioner was highlighted by the Annis Gillie Report[3], which amongst a long list of other recommendations designed to bring the general practitioner closer to the other branches of the NHS, suggested the encouragement of Group Practice. This provided further incentive to the development of health centres.

The 1960s also saw a large number of local experiments involving co-operation between the various agencies concerned with the provision of services, encouraged from time to time by Ministry circulars.[4] These experiments covered geriatric care, mental health, maternity services and child care, and included the re-organisation of administrative sub-divisions in some local authority

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1 661 H.C. Deb. 5s., col. 159

2 Between 1948 and 1964, 21 health centres were built. From 1964 to 1968, 37 centres were built, whilst 67 more were under construction and 66 in an advanced state of planning.

3 Central Health Services Council, Standing Medical Advisory Committee, The Field of Work of the Family Doctor, Report of the Sub-committee, 1963.

4 See, for example, MoH (MH(65)77) asking for liaison between all bodies concerned with the care of the elderly, and MoH (MH(66)24) which stressed the need for co-ordination of services for physically handicapped children and young people.

welfare areas to match hospital areas in mental health; the establishment of joint teams of welfare officers concerned with mental health led by consultant psychiatrists; joint venture geriatric clinics and conferences; social workers providing common services to both hospitals and public health authorities; joint appointments of various kinds; "open-door" policies in hospitals particularly in connection with the follow-up of schoolchildren by local authority medical staff, and liaison posts and meetings of many kinds. There were also experiments in co-operation between general practitioners and the local health authority, and the City of Oxford, for example, claimed complete attachment to general practice for all its health visitors, midwives and district nurses by 1966, and Berkshire, Leeds and Hampshire were in various stages of similar experiments, whilst East Sussex and Bristol were experimenting with alternative schemes. There were also experiments going on in co-operation between general practitioners and hospitals notably at Whittington Hospital in London, and in High Wycombe, where general practitioners were being successfully used as hospital registrars.[1]

A third line in developments concerned changes in epidemiology and medical technology. This involves demographic, social, technological and medical aspects which are all closely interwoven. As far as the population is

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[1] The Health Services and Public Health Act, 1968, was passed in order to establish the legality of these experiments. For a comprehensive survey of these experiments see Hinke, Dorothy E., Working Together, King's Fund, 1968.

concerned, the main changes can be summarised as follows. First, there was an increase in population in England and Wales from 43.5 million in 1948 to 48.4 million in 1967 (+10%). Second, this was associated with increased numbers in those age groups requiring most medical attention, namely the young and the elderly. Between 1951 and 1966 the number of children from 0 to 14 years of age rose from 9.6 million to 10.8 million, whilst the number of people over 65 rose from 4.8 million to 5.9 million. Third, there was large-scale immigration from Europe, from the West Indies, and latterly from Asia. In the 1951 census, about one million persons were born overseas, and by 1966 this had become 1.8 million. New medical needs thus centred upon geriatrics, and to a lesser extent, services needed by immigrants.

Table I

Population Changes (England and Wales) 1948-67 [1]

1948	1951	1966	1967
43.5			48.4 (+10%)
0 - 14 years	9.6	10.8	(+ 1.2)
15 - 44 "	18.7	18.6	
45 - 64 "	10.6	11.8	(+ 1.2)
65+ "	4.8	5.9	(+ 1.1)
80+ "	.6	1.0	(+ .4)
Born overseas	1.0	1.8	(+ .8)
Changing needs:	Geriatrics Immigrants		

The social changes have been summarised by Professor Butterfield.

> "Since the War, economic planning based on Keynesian principles has been associated with a great deal of social legislation. Major programmes for rehousing have been carried through by successive Governments.

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[1] Taken from Butterfield, W.J.H., "Changing Medical Needs", in the Report of the Twentieth Anniversary Conference of the National Health Service, (1968), p.19

> The total number of dwellings per 10 persons has risen steadily from 2.6 at the end of the War to 3.3 today. At the same time the number of hospital beds has remained steady but nevertheless recent operational research suggests that many hospital patients could be treated as well at home - and in view of the expense of hospital in-patient treatment - each case costs £60 or more a week - the changing needs are clearly more domiciliary and out-patient care".[1]

Changes in medical technology have included not only new knowledge about metabolism, protein structure and synthesis, immunology, DNA, RNA, viruses, spare-part and open heart surgery, intensive care and artificial kidneys, but advances in electronics and computing which have had implications for medical research, for analysing data, and in medical administration for accounting, activity analysis, nurses' rotas, innoculation programmes and computer record systems. Automation has also provided laboratory systems for performing a wide variety of bio-chemical tests, and the plastics industry has provided the basis for cardiac catheters and pacemakers.[2] Finally, in terms of epidemiology, it could be said that in 1948 there was an urgent demand for medical care to deal with the diseases of poverty such as hernias, infectious diseases and dental problems. This situation has given way to new needs arising from respiratory diseases such as bronchitis, lung cancer, accidents, mental conditions and old age.[3]

It can be argued therefore, that by the mid-1960s

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[1] Ibid., pp. 14 - 15

[2] Ibid., p. 15

[3] Ibid., pp. 16 - 17

in addition to problems arising from the original structure of the National Health Service, developments in terms of new concepts such as community care, in hospital provision, in epidemiology and medical technology, as well as pressures arising from other policies pursued by governments in local government and the social services, and from within central administration, had made some changes in the structure of the National Health Service probable. However, two questions remain. First, why did all these developments lead to re-organisation becoming an issue at the time it did, in 1967, and second, why did the re-organisation become a fundamental one, rather than an evolutionary adjustment of the structure? These questions will be examined in the following chapter.

CHAPTER III

The Setting:

(A) The Intellectual Climate of Re-organisation and Changes in Administrative Technology

The purpose of this chapter is to place the Central Department and its approach to re-organisation of the NHS in the setting of the administrative and managerial philosophy prevailing in Central Government at this time. The intellectual climate in which administrative re-organisation takes place is an important factor in determining the shape of the final outcome, and there can be little doubt that the climate in which NHS re-organisation took place was extremely important. From the mid-1960s there was much public discussion of the management of government departments, and old-established conventions of public administration were challenged as departments acquired executive responsibilities of large-scale dimensions. The discussion of administrative reform was embellished by such phrases as "a new style of government" and "management accountability", and the application of business methods in appropriate areas of government departments was widely exhorted and in some degree attempted.

The idea of applying management techniques to government was not a new one in the 1960s. Keeling[1] has suggested that the start of the era of management in the public service can be dated back to the Brownlow Committee in the U.S.A., which reported to President Roosevelt in 1937. However,

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[1] D. Keeling, Management in Government, Allen and Unwin, London, 1972.

there was a considerable lapse of time before such ideas were taken up in Britain, and Nairne[1], writing in 1964, could note the arrival of the word 'management' and say "some fifteen years ago ... nobody troubled about management". Keeling has said "certainly few used the word in the public service before the late fifties". He went on to suggest that it began to enter the vocabulary of the Civil Service through a Treasury circular issued in June, 1957, by Sir Norman Brook, then Head of the Civil Service. It read "I am sure that members of the administrative class are not sufficiently alive to the great responsibility which they should carry in these management matters.... They alone can insist upon - and personally secure - maximum efficiency at every level, cost-consciousness all along the line, and effective communication within the organization and with those we serve".[2]

The trend towards concern with management techniques and concepts in the public service in Britain has four strands. First, there is the increasing dissatisfaction with the nature and organisation of the Civil Service and particularly the Administrative Class, which was ultimately to result in the establishment of the Fulton Committee. In 1959, Hugh Thomas[3] edited a collection of essays entitled

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[1] P.D. Nairne, "Management and The Administrative Class" in Public Administration, Summer, 1964, p.113

[2] D. Keeling, Management in Government, Op. Cit., p.18

[3] H. Thomas (ed.) The Establishment, Anthony Blond, London, 1959, p.83 ff.

"The Establishment" which included an essay on the Civil Service by Thomas Balogh which concentrated upon the lack of technical expertise on the part of the top administrators in the Civil Service, and criticised the Treasury for using its patronage to ensure the acceptance of administrators who had no professional training and the inferiority in status and pay of the technical and specialist classes.

In 1963, Professor Brian Chapman[1] in "British Government Observed" made unfavourable comparisons between the training and experience of the British Administrative Class and the corresponding class in France. In 1964, Mr. Harold Wilson in an interview with Dr. Norman Hunt[2], commenting upon the machinery of government, spoke of combing the Civil Service for specialists, bringing in outside experts and of building up the Cabinet Secretariat to include staff with experience of economic administration, and also bringing in groups of experts from inside and outside the Service who would undertake long-term studies. In the same year, the Fabian Society published "The Administrators" which was believed to have been written by a group of senior civil servants. This described the Administrative Class as "isolated from industry, local government and other fields of society", as "closed as a monastic order with no inward or outward movement" and as "having no provision for appointments from outside". This led the authors to make three

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[1] B. Chapman, British Government Observed, Allen and Unwin, London, 1963, p.31.

[2] N. Hunt, Whitehall and Beyond, BBC Publications, London, 1964, pp. 11 - 28.

criticisms of the Administrative Class, namely, amateurism; an emphasis on procedures rather than the substance of problems; and too much secrecy in the formulation of policies. They pointed to the need for civil servants to be able to assess costs, risks, interactions in quantitative terms, and to the need for a reform of the personnel management function in government departments and the Treasury, in view of the latter's emphasis upon economy and its treatment of personnel work as a by-product of controlling expenditure.[1]

The election campaign of 1964 saw the Labour Party emphasise the necessity for managerial and technological efficiency. This reflected the interest of Mr. Wilson in science and technology, supported by two of his closest friends and advisers Thomas Balogh and John Fulton[2]. The Labour manifesto "Signposts for the Sixties"[3] suggested that the economy was dominated by a small ruling caste and that the dead wood should be cut out of Britain's boardrooms and replaced by keen young executives, production engineers and scientists who had hitherto had been denied their legitimate prospects of promotion. Following the election, the Estimates Committee of the House of Commons considered, in 1965, the question of recruitment to the Civil Service, and concluded that the structure and public image of the Civil Service needed to be reviewed in the light of modern needs and

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[1] Fabian Society, The Administrators, Fabian Tract No. 335, London, 1964.

[2] P. Foot, The Politics of Harold Wilson, Penguin, Harmondsworth, 1968, p. 149.

[3] Labour Party, Signposts For The Sixties, 1964.

recommended that a committee of officials, aided by members from outside the Civil Service, should be appointed to initiate research and to examine and to report upon the structure, recruitment and management of the Civil Service and that, on receipt of this report, the government should consider the need to appoint a Royal Commission[1]. The government set up a committee under Lord Fulton in 1966 with a majority of members from outside the Civil Service to examine the structure, recruitment and management, including training, of the Civil Service and to make recommendations[2]. The appointment of this committee came as the culmination of increasing dissatisfaction with the higher Civil Service, which "was part of a wider demand by journalists, academics and radical politicians for the modernization of British institutions. The movement was fuelled by a feeling that the management of these institutions was socially exclusive and closed to outside scrutiny, and that they were accountable only to themselves"[3].

The Labour Party was amongst those who sent evidence to the Fulton Committee, and its complaints were thought to be the accumulation of grievances felt by the government in its two years of office. It referred to the highly complex techno-industrial society which the Civil Service was now called upon to manage, and to the more specialized technical skills required. It criticised the amount of information

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1 Sixth Report of the Estimates Committee, Recruitment to the Civil Service, August, 1965, pp XXIV - V, H.C. 308

2 Report of the Committee on the Civil Service (Fulton, Ch.) Cmnd. 3638, 1968.

3 D. Keeling, Management in Government, Op. Cit., p.35

withheld from Ministers which made them "tools of their departments a good deal of the time" and said that "inter-departmental committees of officials are a particularly effective way of undermining the authority of Ministers". It was proposed therefore that an incoming Minister should have the right to appoint a personal cabinet of assistants who would have access to him and to all the information in his department, and that temporary appointments of expert advisers in 'posts of confidence' with direct access to Ministers, should also be made[1].

One significant feature of the Fulton Committee was that it set up a Management Consultancy Group, which started work in 1966 on examining in detail the management and organization of a number of blocks of work in the Civil Service, comparing these with the best practice in business firms, and giving consideration to the responsibilities held by the staff, the tasks performed, the skills the work called for and the relationship between specialists and administrators[2].

In its report, the Consultancy Group indicated its view that the career class structure was a major obstacle to efficient management in the Civil Service and proposed a 'unified grading structure' based on job evaluation. It also suggested lines of research into a new managerial style for the Civil Service based on the definition of objectives and priorities for organisational units derived from the definition of managerial objectives rather than hierarchies

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[1] Report of the Committee on the Civil Service (Fulton, Ch.) Cmnd. 3638, 1968, Volume 5, Memorandum No. 97.

[2] Ibid, Volume 2, Report of a Management Consultancy Group, 1968.

of career classes. It referred to the need for more sophisticated forms of management accounting and control, and greater delegation of responsibility to individual managers supported by procedures for assessing accountability and for measuring managerial effectiveness. To establish the long-term policy framework for these systems of objective-setting and control, new high-level departmental planning units were required.

The Fulton Committee itself commented that too few civil servants were skilled managers. It suggested that members of the Administrative Class, in particular, who were allotted the major managerial role in the Service did not see themselves as managers of departments but as advisers on policy to those above them. Its recommendations included the setting up of a Civil Service College to provide training in administration for specialists, post-entry training for graduates recruited for administrative work, courses for the best school leavers, post-experience courses in management and in particular, management techniques. It also recommended that the principles of accountable management should be applied to the Service, i.e. individual managers should be held responsible for their performance, measured as objectively as possible; each department should have a management services unit capable of carrying out efficiency audits involving all aspects of the department's work at all levels; departments should have planning and research units with responsibility for long-term policy planning, headed by Senior Policy Advisers with direct and unrestricted access to the Minister; and the central management of the Service

should be made the responsibility of a new department, the Civil Service Department, which should absorb the functions of the Pay and Management side of the Treasury and those of the Civil Service Commission[1]. These recommendations were largely accepted by the government, and since the report there has been a distinct improvement in the status and scope of management services in the Civil Service.

A second strand in the tendency towards management is to be found in the development of techniques relating to the control of public expenditure. It became clear in the 1950s that in some fields, notably defence, education and road-building, a single year as a time-span over which to plan expenditure was quite inadequate, and this led to the use of longer-term 'forward looks'. In 1957-8 the Select Committee on Estimates[2] criticised Treasury planning and control of expenditure, and found 'somewhat disturbing' the lack of appreciation on the part of the Treasury of the need to review established policies involving expenditure, and the lack of any constructive approach to the situation. It therefore called for a systematic and regular review of existing policies in terms of their prospective expenditure. It criticised the "natural tendency, within the present system of estimates and accounts to concentrate too much attention on the policy and expenditure proposals for the coming financial year with too little regard to the commitments and consequences for future years ... an obsession

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[1] Ibid, Volume 1, pp. 104 - 106

[2] Sixth Report, Session 1957-8, Treasury Control of Expenditure, H.C. 254, July, 1958.

with annual expenditure can stultify forward planning"[1]. The Committee urged that a small independent committee be established to report on the Treasury control of expenditure[2]. The government responded by setting up an internal inquiry under Lord Plowden. The Plowden Committee noted that in defence, nationalised industries, education and pensions the practice of regular 'forward looks' had become established, and that long-term programmes for hospital building and five-year progremmes for motorways were in existence. In most departments however, no criteria existed to form the basis of rational choice and piecemeal decisions were made. The Committee proposed therefore that "Public expenditure decisions whether they be in defence or education or over-seas aid or agriculture or pensions or anything else, should never be taken without consideration of (a) what the country can afford over a period of years having regard to prospective resources and (b) the relative importance of one kind of expenditure against another". It recommended that "Regular surveys should be made of public expenditure as a whole, over a period of years ahead, and in relation to prospective resources, decisions involving substantial future expenditure should be taken in the light of these surveys". It also pointed to the necessity for improvement in techniques for dealing with public expenditure problems including the use of more quantitative methods, and for more effective machinery to enable Ministers to take collective decisions and exercise collective responsibility on matters of public

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[1] Ibid., para. 23, p. xi

[2] Ibid., para. 95, p. xxxvii

expenditure[1]. As a result, since 1961, annual surveys of public expenditure have been prepared for Ministers by the Public Expenditure Survey Committee on the lines put forward by Plowden. These surveys look five years ahead and are prepared on a rolling basis in an annual cycle which runs parallel to the preparation of supply estimates.

Associated with the development of the PESC system has been the introduction of Programme Analysis and Review, developed by a team of businessmen in the Civil Service Department from 1970. This is an embryonic form of Programme, Planning and Budgeting systems, and involves the display of expenditures in a way which relates them to major policy objectives and cost-benefit analysis relating to alternative ways of achieving these objectives. It had its origins in the United States Department of Defense at the instigation of Robert McNamara, Defense Secretary and his Assistant Secretary Charles J. Hitch, who had come from RAND, a research consultancy involved in the early design of the system. The results were sufficiently encouraging to cause President Johnson to order its adoption throughout federal agencies in 1965. It was first applied in the U.K. at the Ministry of Defence in 1963, was in operational use there by 1965, and by 1970 had made a major contribution to the eight reviews of the defence budget between 1964 and 1970. It has also been developed in the Home Office for local police forces, and in 1970 a Treasury feasability study for PPB in the Department of Education and Science was published. PAR was foreshadowed in the White Paper on the Re-organisation

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[1] Report of the Committee on the Control of Public Expenditure, (Plowden, Ch.), Cmnd. 1432, 1961.

of Central Government in 1970, and was intended to balance the tendency of the PESC system to concentrate attention upon division of resources between departments rather than upon the examination of what each department was proposing to do. It provides for submission by departments of statements of objectives and priorities for central consideration before the process of allocation begins. This is possibly even more important to the 'giant' departments in their own operations than to interdepartmental allocation operations, and PAR is essentially a departmental exercise.

The growth of giant conglomerate departments is a third strand in the development of management techniques and concepts in government. Since 1966 there has been a drastic reduction in the number of departments. The Commonwealth Office and Ministry for Overseas Development has been merged with the Foreign Office; the DHSS has been formed by merging the Ministries of Health and Social Security; Trade, Technology and Power were replaced by the Department of Trade and Industry; and Transport, Housing and Local Government, Land and Natural Resources, and Public Building and Works by the Department of the Environment. Thus, instead of some 19 or 20 departments, there is now likely only to be nine or ten departments in Whitehall. This has been accompanied by changes in the functions of the centre in relation to departments. The centre now works on departments' objectives and priorities or PAR and the analysis of issues for the Cabinet, which is done by the Central Policy Review Staff and the Treasury. There is also public expenditure allocation (PESC) and its control, done by the Treasury's public

sector divisions. In addition, there is the control of staff numbers, manpower and organisation, senior appointments and management services in departments, now done by the Civil Service Department. This involves the centre and departments in taking joint decisions about the constraints of resources, money and manpower within which each department must work, and these constraints must be determined by the Cabinet. The centre must also ensure that departments comply with these constraints, and this is also a joint operation. Disputes or incompatibilities between departments have also to be sorted out by the centre and departments together. As Clarke has put it "The nature of the relationship between the centre and the departments is the crux of the ability of the whole governmental machine to work smoothly and effectively"[1]. The Plowden Committee suggested that the relationship "should be one of joint working together in a common enterprise; it should be considered not in terms of more or less 'independence' of the departments from 'control' by the Treasury [and Civil Service Department] but rather in terms of getting the right balance and differentiation of function"[2].

Until 1970, there does not appear to have been any theory, philosophy or statement of principles stated publicly about the change taking place in the number and scope of departments, although particular examples such as the organisation of the defence departments had been carefully explained. Indeed, Robson has suggested that the reason for

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[1] Sir Richard Clarke, New Trends in Government, HMSO, London, 1971, p. 41.

[2] Para. 34

uniting the functions of the Ministry of Health and the Ministry of Social Security was the desire to give Mr. Crossman the status of a Secretary of State, as "nothing occurred after the merger to demonstrate an organic relation between the National Health Service and the administration of cash payments under the national insurance and supplementary benefit schemes"[1].

A fourth strand in the move towards management can be suggested to be the views and activities of politicians in this field. In this connection, from the point of view of NHS re-organisation, it is probably the attitude of Mr. Heath and his colleagues, both in opposition and, after 1970, in government, which is most important in shaping the outcome.

On becoming Leader of the Opposition in 1964, Mr. Heath set up a number of study groups to review policies with the benefit of outside specialist advice. In addition to these study groups, there were 'private armies' reporting directly to Heath, including one headed by Mr. Ernest Marples which looked at the application of scientific management techniques to the machinery of government. It was known as the Conservative Public Sector Research Unit, and was assisted by Mark Schreiber of the Conservative Research Unit, and two major firms of management consultants who had been engaged in similar work for foreign governments. From this came Heath's intention to bring businessmen of managing...

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[1] W.A. Robson, "The Re-organisation of Central Government", Political Quarterly, Vol. 42, 1971, p. 87.

director calibre into Whitehall[1].

Heath was well aware that major changes had taken place in structures and procedures in Whitehall since the last Conservative government, and that further changes were in view. The Fulton Report was to lead to increased delegation of responsibility in all departments and the development of accountable management, and the Civil Service Department was to add impetus to these and other developments such as programme budgeting, in conjunction with the Treasury's Management Accounting Unit which placed greater emphasis on objectives in government activities and the cost of achieving them.

Heath also took the view that the Fulton Report had political significance for the Conservative Party which had become concerned about the growth and centralisation of power in modern Britain and the capacity of party politicians to control the administrative machine. This thinking was also reflected amongst a significant element in the electorate, where concern was widespread about the level of public spending, and there was some expectation that the Conservatives would be able to deal more authoritatively with this and other problems of government machinery and bureaucracy than Labour. This would have to be reconciled with some Conservative policies, such as a continuing presence east of Suez, which would involve increased public spending. Thus, in order to exert tighter discipline over public expenditure and to reduce the proliferation of activities

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[1] George Hutchinson, Edward Heath: A Personal and Political Biography, Longman, London, 1970, pp. 178 - 180.

which gave rise to it, the Conservatives turned to a policy of greater provision of community requirements through private enterprise, voluntary effort and the operation of the price mechanism. This would involve the re-allocation of central government responsibilities, and the administrative difficulties which would have to be overcome required sound organisational principles and techniques. Heath argued that by offering real responsibility for the management of clearly defined programmes and the achievement of defined policy goals, business managers of the highest calibre could be brought into Whitehall on a new and worthwhile basis. He was aware that without Civil Service co-operation he would not succeed, but considered that clearer definition and delegation of tasks would increase political power over the administrative machine, and that the success of the next Conservative government would depend heavily on their ability to establish and use effectively this increased degree of control.

Amongst the ideas that were proposed in this context was the identification of additional areas where greater emphasis might be laid on separate responsibilities, separate projects, and 'hiving-off' into separate agencies. It was also argued that a new capability was required to improve the quality of information received by the Cabinet so that there would be a better basis for more systematic questioning and control of departmental activities by Ministers, although it was not clear how any new unit might be fitted in with the Civil Service Department, the Cabinet Office, Treasury and other support staff.

Another of Heath's groups, which included five former civil servants in its ranks, considered the re-organisation of government departments, which also involved considerations of efficiency and economy in both costs and numbers, and this group tended to think in terms of a 'federal' system in Whitehall which would group appropriate ministries together.

Thus, Heath was much concerned with 'preparation for government', streamlining the Civil Service, a reduction in the number of departments and staffs, a smaller Cabinet, and above all, with establishing a system to enable Ministers to exercise 'more direct control over the strategy of longer-term policy', and which would release them from immersion in the routine daily administration of departments to give attention to the objectives of overall policy[1].

When the Conservatives were translated into government in 1970, many of the ideas on the machinery of government developed in Opposition were contained in its White Paper on the Re-organisation of Central Government[2]. Mr. David Howell, who had first assisted, and then succeeded Mr. Ernest Marples in the Conservative Party Research Department, had foreshadowed the White Paper in two pamphlets published in June, 1968[3], and May, 1970[4]. The White Paper indicated the aims of the new government to be the reduction in the scope and amount of government and the improvement of

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[1] Ibid., p. 183.

[2] The Re-organisation of Central Government, Cmnd. 4506, 1970.

[3] David Howell, Whose Government Works? CPC, 1968.

[4] David Howell, A New Style of Government, CPC, 1970.

its quality. This would involve the improvement of the framework within which public policy is formulated so that Ministers could be provided with a choice of real alternatives. The analytic approach would be used to determine priorities and ensure that future policies were in accord with the Government's general view of the proper sphere of action. The White Paper accepted the functional principle as the main guide to the re-organisation of departments, with departments given as wide a span of related functions as possible in order to provide a limited number of spheres of unified policy. This would facilitate a single strategy for major purposes, and the easier resolution of conflicts than that achieved by inter-departmental compromise, together with the ability to manage and control more ambitious programmes in selected fields. Unification of functions would lead to the attainment of a more comprehensive approach to government organisation, and any difficulties caused by size would be overcome by clearly defined 'functional wings' within major departments and the delegation of large blocks of work to 'accountable units of management'. Perhaps the most interesting feature of the White Paper was the proposal to establish a small multi-disciplinary central policy review staff in the Cabinet Office, under the supervision of the Prime Minister and at the disposal of the Government as a whole. It would assist Ministers to improve the quality of policy decisions by working out the consequences of basic strategy in particular spheres, determining relative priorities between competing claims in the entire governmental programme, to indicate areas where opportunities for

new policies might be available, and to ensure that the implications of practicable alternatives were fully explored before a course of action was determined[1].

This is, in outline, the intellectual climate in which re-organisation of the NHS took place. Its significance for the NHS is that during much of the time that the discussions on re-organisation were taking place, the Ministry of Health and its successor, the DHSS, were regarded both inside and outside Whitehall as departments which were weak in management terms and had failed to apply techniques of modern management effectively in their efforts to control the growth of public expenditure on health.

As Glennerster[2] has pointed out, much of the Treasury's concern was motivated by the desire to use their control mechanisms for short and medium term demand management. This was associated with attempts to reduce or contain the growth of government expenditure and especially to restrain the level of social service budgets in the face of demographic changes which tended to force them up and the labour intensive nature of the social services which meant that raising real salaries meant raising costs relative to less labour intensive services[3].

Glennerster has argued that the reforms in the control of public expenditure "were largely prompted by a desire to constrain the growth of government"[4]. Heclo and

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[1] The Re-organisation of Central Government, Cmnd. 4506, 1970, para. 46, p. 13.

[2] H. Glennerster, Social Service Budgets and Social Policy, Allen and Unwin, London, 1975.

[3] Ibid., p. 119 and P. 125.

[4] Ibid., p. 117.

Wildavsky[1] have suggested that the origins of the new system of public expenditure lie in the frustrations experienced by the Treasury and its Ministers in the late 1950s. "Earlier in the decade the Conservative Government had managed to contain the growth of public expenditure. Indeed, in real terms, it had been allowed to grow at less than one half of a per cent a year between 1952 and 1958. As a proportion of the GNP it had fallen steadily from 47.0 per cent in 1952 to 41.6 per cent in 1958. Excluding transfers there had been no increase in the actual resources devoted to the state sector in this period"[2]. Cuts in military expenditure following the end of the Korean War had been partly responsible, but the social services also made an important contribution, and from the beginning of this period the NHS took a declining share of the GNP until the mid-1950s. "So much of the government's social policy was designed to reduce or contain the growth of government expenditure and, at least until 1957, it had some success despite suggestions to the contrary"[3]. However, from 1957, there were indications that the strategy was no longer working, as military expenditure could only be reduced quickly within limits, and pressures were also building up with the social services[4]. The Guillebaud Report[5], for example, indicated that the NHS was

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1 H. Heclo and A. Wildavsky, The Private Government of Public Money, Macmillan, London, 1974.

2 Sir Samuel Goldman, The Developing System of Public Expenditure Management and Control, HMSO, London, 1973, p.73.

3 H. Glennerster, Social Service Budgets and Social Policy, Op. Cit., p.119.

4 Ibid.

5 Report of the Committee of Enquiry into the Cost of the National Health Service, Cmnd. 9663, 1956.

being neglected, whereas the government had hoped it would assist them to economise on the service, and there were political limits on the extent to which further cuts could be made. As Glennerster has put it, "It was against this background that the spending ministers began to win more battles. The strategy of the early 1950s was collapsing. At the end of 1957 the Cabinet rows and the Treasury's unease broke the political surface"[1]. The resignation of the Chancellor of the Exchequer, Mr. Peter Thorneycroft and his two junior colleagues occurred in January, 1958, not merely because the cuts they had asked for in Cabinet were defeated, but because this was one of a whole series of defeats for the Treasury in Cabinet and its committees. This led the Treasury to conclude that the system of control of public expenditure it had been operating was to blame, and should therefore be changed. "In the end Treasury officials such as Richard Clarke, David Serpell, Matthew Stevenson, William Armstrong and others won out because a strong feeling crystallised in the Treasury that it was being defeated far too often. Spending, the victorious faction believed, was not being controlled by anyone"[2]. It was this situation which led to the Plowden Report.

In these circumstances it is not surprising that the Treasury was often critical of the Ministry of Health's tentative approach to the management of its administrative

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[1] H. Glennerster, Social Service Budgets and Social Policy, Op. Cit, pp. 119 - 20.

[2] H. Heclo and A. Wildavsky, The Private Government of Public Money, Op. Cit, p. 203

subordinates. Treasury officials were apt to see the Ministry of Health as regarding the various NHS agencies as working to a considerable degree "on the principle of States' Rights in a loose Confederation". There was also concern that the Ministry would envisage no significant change in its relationship with the proposed Area Boards from that which prevailed between the Ministry and the Regional Hospital Boards, that is, "a disposition to treat them with kid gloves".

This attitude of the Treasury to the Ministry of Health can be detected in the establishment of an inter-departmental committee between the Treasury, Department of Economic Affairs, Ministry of Health and Scottish Home and Health Department in 1966. This was the Health Programme Committee which Gunn and Mair[1] have referred to as Treasury 'supervision' of Health. The Committee took as its first subject the trends in the hospital service. The discussions placed emphasis on such aspects as regional differences in management efficiency in the service, economies in the use of productive space in new hospitals, improvements in manpower productivity, forward planning of the need for hospital beds, establishment of appropriate units of measurement in relation to the functional units in hospitals, standardisation of components, the concept of the 'best-buy' hospital, investigation of the running costs of hospitals particularly in relation to setting expenditure and manpower norms, the

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[1] L. Gunn and R. Mair, Big Medicine For The Health Ministry, New Society, 20 July, 1967.

feasibility of establishing 'medical norms' for example in relation to length of hospital stay in normal cases of a commonly-occurring type, and the revenue implications of new building. Emphasis was laid on the fundamental importance of efficient management in the economical provision of the hospital service, and it was clear that the Ministry was making some effort in this direction with the setting up of a National Committee responsible for management training for nurses, and the publication of a report on a recruitment and development scheme for administrative staff. It was regarded as essential that senior medical and nursing staff should be brought into the management process in such a way as to combine efficient management with the necessary professional freedom. The Health Programme Committee recognised that this would require effective central guidance and control which had hitherto been exercised lightly as a matter of policy, and that the development of the new policy would need to be carefully considered and presented, whilst such guidance and control should go no further than was necessary and did not imply detailed administration from the centre. A subsequent high-level discussion of the work of the Committee by senior members of the departments concerned saw the need for fuller central control and guidance, and for assessment of the results to be achieved from a given investment of resources for the hospital services which would require more effective assembly and use of information and a wider understanding of the need to take account of economic as well as medical factors.

The Treasury's concern was reflected also in its attempts to 'colonise' the Ministry of Health by the transfer

of its officials to administrative posts in that Ministry. As Kogan[1] has indicated, this is a general tendency over all the social service departments, and as Glennerster has pointed out, this was responsible for the scorn poured on the Fulton Committee's proposal that recruitment and promotion within the Home Civil Service should be specialised, and recruits should be prepared for promotion within two sets of departments, social administration and the economic departments, with most civil servants spending most of their time in one or the other group. This scorn is perhaps not surprising as "part of the Treasury's influence has come from the fact that its own men have gone on to 'colonise' the major social service departments"[2].

However, it was not only the Treasury which felt that there was cause for concern in the approach of the Ministry of Health, and subsequently the DHSS, to the management of its administrative agencies. Ministers associated with the Department, notably Richard Crossman, found difficulties arising from its lack of direction. As Klein has pointed out, Crossman attempted, in 1969, to switch resources from the acute to the chronic sector. "In this attempt, he failed. And the reason for this failure is significant. He failed but not because the medical profession acted as an organised pressure group to stop him; there were

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[1] M. Kogan, Social Services: Their Whitehall Status, New Society, 21 August, 1969 and Government of the Social Services, 16th Charles Russell Memorial Lecture, 1969.

[2] H. Glennerster, Social Service Budgets and Social Policy, Op. Cit., p. 79.

no protests from the BMA, no campaign by the organised medical interests. It was, however, made clear to Crossman by his civil servants and by the chairmen and officers of the regional hospital boards that a diversion of existing resources was unacceptable to the profession"[1]. Crossman himself concluded that in the NHS "You have a number of powerful semi-autonomous Boards whose relation to me was much more like the relation of a Persian satrap to a weak Persian Emperor. If the Emperor tried to enforce his authority too far he lost his throne or at least he lost his resources or something broke down. In much the same way Health Service freedom lies in the fact that the centre is weak and the Regional Hospital Boards are strong, while the GPs in their enclave are separated off safely from attack"[2].

Parliament also was not unaware of the position. Its Select Committee on Science and Technology[3], which looked at population growth in the United Kingdom, complained of a lack of urgency and of the complacency it found in Government Departments in relation to the formulation of a population policy. Evidence indicated that nothing significant was being done by either the Medical Research Council or the DHSS, and that there was a lack of co-ordination of activities in the field of population growth and structure between the

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[1] R. Klein, Policy Problems and Policy Perceptions in the National Health Service, Policy and Politics, March, 1974.

[2] R.H.S. Crossman, A Politicians View of Health Service Planning, University of Glasgow, 1972, p. 10.

[3] Select Committee on Science and Technology, Session 1970-71, H.C. 379.

Medical Research Council and the DHSS. The Rothschild Report[1] took up a similar theme in connection with the inadequate relationship between the Medical Research Council and the DHSS. "According to the DES an appreciable part of the work of the MRC ... is applied. But this work had and has no customer to commission and approve it. This is wrong. However distinguished, intelligent and practical scientists may be, they cannot be so well qualified to decide what the needs of the nation are, and their priorities, as those responsible for ensuring that those needs are met. This is why applied R and D must have a customer ..."[2]. It went on to say "The interaction between the DHSS and SHHD and the MRC has, so far, been inadequate and the changes recommended .... are intended to rectify this deficiency. At present, although the DHSS and SHHD have direct responsibilities in the field of public health, they have no share, as of right, in MRC decisions and cannot be certain of always being consulted about the MRC's work on, for example, nutrition, toxicology, vaccines and blood transfusion. The same applies to clinical medicine, despite the direct responsibility of DHSS and SHHD for the NHS; to cancer and radiation; to ageing (on which the MRC spent £9,000 in 1970-71); to cardio-vascular disease, renal disorders and rheumatism; to endo-crinology, psychiatry and psychology, neurology (special services), and occupational health. The same applies to

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[1] A Framework for Government Research and Development, Cmnd. 4814, 1971, The Organisation and Management of Government R & D by Lord Rothschild.

[2] Ibid., p. 4

epidemiology and social medicine. In the light of these factors a good case could be made for transferring to the DHSS and, where relevant, the SHHD about £11 million out of the DES total of £22.4 million (1971-72)"[1]. It suggested that "Because of the rather small size of the DHSS and SHHD participation in the MRC's affairs and because of the intimate relationship which should exist between those Departments and the MRC, the Chief Medical Officers of the DHSS and SHHD should be Members of the Medical Research Council, not only Assessors to the Council. In addition, both Departments should be represented on those Boards and Committees of the MRC which are relevant to their interests"[2].

The Expenditure Committee[3] also found indications of a lack of management technique at the DHSS. "The Treasury said that, at any rate until recently, Governments had relied mainly on the 'feel' of Departments, rather than on an objective system of information. The Department of Health and Social Security, giving evidence on their programme for services to the elderly, gave us a good example of this approach. They said that they were at a very early stage in working towards a complete information system and that they relied mainly on the knowledge and experience of the Department itself and of the specialist divisions to guide them to what they hope was a reasonably rational set of choices"[4].

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[1] Ibid., p. 21.

[2] Ibid., p. 13.

[3] Expenditure Committee, Eighth Report, Session 1971-72, Relationship of Expenditure to Needs, H.C. 281.

[4] Ibid., p. vi.

Griffith[1] has indicated the Ministry of Health's lack of management control over local authorities. He has suggested that there are three separate attitudes which Government Departments manifest towards local authorities, laissez-faire, regulatory and promotional, and he puts the Ministry of Health firmly in the laissez-faire category with regard to both health and welfare functions[2]. He also suggests three ways in which the Ministry of Health seemed to be doing less than some parts of other departments, namely, in the collation, analysis and dissemination of the experience of local authorities; in research; and in insisting that local authorities followed departmental policies[3].

Griffith cites as an example of the Ministry of Health's approach the initiative taken in the preparation of the ten-year plans and their revision, which was the first step in the creation of minimum standards. "The next step to be expected was the requirement that local health and welfare authorities should as soon as possible bring their services up to those standards where they had not already done so, and then to seek to raise the performance of all local authorities to the level, if not of the best, at least to that of the good. But the Department seems to be reluctant to insist. The Department prefer, for a variety of different reasons, to stop short at advice and exhortation. The result is that the follow-up letters to individual local

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1 J.A.G. Griffith, Central Departments and Local Authorities, Allen and Unwin, London, 1966.

2 Ibid., p. 515.

3 Ibid., p. 494 - 5 and p. 515.

authorities take this form"[1].

According to Griffith, the Department justified this on three grounds. First, there was the shortage of trained social workers; second, variations in local conditions; and third, it was argued that these were local authority services and too much intervention would conflict with the spirit of the legislation[2]. Griffith contends, however, that "This begs the major question for, with very few exceptions, of which section 1 of the Education Act is the most obvious example, legislation rarely spells out with any precision how far the departmental powers should override those of local authorities. The statutory powers of local authority are expressed in the schemes or proposals submitted to and approved by Ministers, and those schemes and proposals, though broadly drawn, do place on local authorities obligations which, if the Department wished so to interpret them, could frequently be said to be unfilfilled. Moreover, the Minister has statutory power himself to amend proposals and to vary schemes, if local authorities fail to do as he requires. Local Welfare authorities exercise their functions, including any discretion, conferred on them, 'under the general guidance of the Minister, and in accordance with regulations with respect to the qualifications of officers employed by local authorities or voluntary organisations. For both health and welfare services, the Minister has the usual powers of declaring local authorities to be in default and, where necessary, of carrying out their duties himself and charging their expense on the local authority"[3].

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[1] Ibid., p. 488.

[2] Ibid., p. 489.

[3] Ibid., pp. 490 - 1.

However, Griffith suggests that virtually the only genuine form of statutory control used by the Minister was the withholding of recommendations for loan sanctions. This has the limitation that it only affects capital projects financed by borrowing, whereas local authorities finance 20 - 25 per cent of capital projects out of revenue, and does not assist the Department when it seeks to promote activities[1].

The Department also has statutory inspectors, but in practice the Department do not use their officers as inspectors in the same way as the Home Office, for example, used their children's inspectorate or that HMIs are used for schools, "because to do so would conflict with the preference of the Department to proceed by advice and exhortation rather than by more disciplinary or rougher methods. Welfare Officers and others visit old people's homes and other institutions, they make reports, and letters to local authorities may follow. But local authorities do not regard them as exercising the same sort of disciplinary powers as are exercised by the Home Office inspectorate"[2].

Arguably then, the Department has had the statutory powers if it wished to exercise them, and although these powers could be considered limited, the interpretation of the powers has been much narrower than it might have been. Griffith has cited two principal causes of this philosophy. First, it regarded, (and probably still does) many of the services provided as essentially experimental and at the

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[1] Ibid., p.491

[2] Ibid., p.491

developmental stage which made a more insistent attitude inappropriate. Second, the local medical officers of health were professional men of considerable experience, and without the direct hierarchical relationship found in hospitals, the medical staff at the Department would not seek to instruct any professional medical colleague on a matter of professional opinion[1].

Griffith noted that even where positive guidance was given, the absence of follow-up to see if local authorities had conformed gave local authorities the impression that compliance or otherwise was a matter of no great import. "There is no consciousness in local authorities that they had better pay regard to the Department's views lest worse befall. And they, in practice, not infrequently pursue their own courses, even where they will eventually need loan sanction, if they feel that the Department are not likely to press their view too vigorously"[2].

It may be that the reason for this attitude is to be found in the traditional role of the Department as the principal local government department, which has implanted a greater traditional respect for local authorities as independent entities in their own right. The Ministry certainly took "more seriously than many" the recommendations of the Local Government Manpower Committee and the discussions in connection with the general grant of 1958 which aimed in part at reducing departmental influence in local authorities' affairs". Recent history may also provide a further reason,

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[1] Ibid., pp. 492 - 3.

[2] Ibid., p. 497.

particularly for the welfare services. The Poor Law inspectorate were feared. And when new dispensations were given, a break with the old attitudes was deliberately sought"[1].

Writing in 1965, Griffith described the Department as giving the impression "of being anxious to promote the services, to evolve the necessary standards, and to encourage members and officers of local health and welfare authorities to put their plans into effect. But at the same time, the Department also give the impression of being unwilling to make a nuisance of themselves, to cajole, even to bully those authorities whose performance is less than it might be. This is not to suggest that government departments necessarily get the best or the quickest results by beating such local authorities over the head. But in comparison with the relationship between some other departments and their local authorities, the Ministry of Health shows a marked reluctance to be even strongly persuasive. And this appears to be the result of its tradition and its philosophy"[2]. He concluded, "The Ministry of Health give the appearance today of being caught between two eras: the past era when the general attitude to the solution of social problems was less ambitious than it is today; and the future era when the positive responsibilities of public authorities will surely be regarded as unarguable and when marked differences in the quality of services provided by individual local authorities

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[1] Ibid., pp. 517 - 8.

[2] Ibid., p. 499.

will not be tolerated even though this may mean less autonomy"[1].

Other observers have cited health centre proposals and their implementation as another instance of the Ministry of Health's tentative approach to management[2]. "It is important to see the implementation of the health centre proposals within the context of the Ministry of Health's approach towards local authority planning generally". They continue, "With regard to health centres, it was certainly clear that it adopted a non-interventionist role; the extent of its influence on the development of the scheme being the approval or otherwise of the plans submitted for loan sanction and the rather haphazard dissemination of information by the department's medical officers"[3]. Sir George Godber, the Deputy Chief Medical Officer at the Ministry of Health acknowledged the nature of the approach and argued its merit. "It would not be right to formulate a plan for the development of general practice centrally and then impose it .... The function of planning is to provide outside aids to the extent that they may be desired, and to make sure that the other parts of the health service are planned for their proper supporting role; in fact, to give general practice the best possible conditions for evolution"[4]. However, this

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[1] Ibid., p. 518.

[2] P. Hall, H. Land, R. Parker and A. Webb, Change, Choice and Conflict in Social Policy, Heinemann, London, 1975.

[3] Ibid., p. 291.

[4] Sir George Godber, Health Services, Past, Present and Future, in The Lancet, ii, 1958, pp. 2 - 6

laissez-faire attitude on the part of the Ministry brought complaints about lack of encouragement from some local authorities, notably the London County Council, during the 1950s[1].

Davies has similarly commented upon the relationship between the Ministry of Health and its field agencies. Regional advisory staff and the inspectorates are the vital link between operational reality and central reality in the social services, but the strength of the link varies. The Home Office, for example, was generally considered to have good contact with the field when it was responsible for the child care services. By way of contrast the old Ministry of Health was towards the other end of the continuum in its relations with the operational units of the health service, especially the local authorities. Its contact with the local authorities' welfare functions (under the National Assistance Act, 1948) was further along the continuum still"[2].

Klein has indicated that the new DHSS inherited many of the features and attitudes of its constituent Ministries, and that the health and social security parts "have little to do with each other". He has suggested that the health section has a number of unique features among Whitehall departments. First, there is the parallel hierarchy of civil servants and medical administrators, with the former dominant. Second "the DHSS has inherited what one academic

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[1] London County Council, Development of Health and Welfare Services, 1962 - 1972, p. 5, quoted in P. Hall et al. Change, Choice and Conflict in Social Policy, Op. Cit., p. 292.

[2] B.P. Davies, Social Needs and Resources in Local Services, Michael Joseph, London, 1966.

charitably described as a laissez-faire attitude to administration. Indeed, one exasperated Minister of Health complained that the only hope of improving the NHS was to blow up the Ministry and start again[1]."

Two examples are cited by Klein of the tentative style of administration which prevailed in the Ministry of Health and subsequently in the DHSS. First, there is the failure to enforce a more equitable distribution of resources, per head of the population, between the regions. Second, there is the failure to obtain a positive response from hospital management committees to circular HM(64)102 on improving out-patient departments and cutting excessive waiting times. "The paradox is - as Richard Crossman has pointed out - that in many respects the DHSS exercises less control over the nominated bodies which spend its money than the Department of Education has over the elected authorities who spend the ratepayers' money on schools". Arguably, the DHSS reversed the most basic precept of management and concentrated on book-keeping to the neglect of strategy formation, and compensated for the looseness of its control in some respects by an obsessive preoccupation with detail. Klein went on to point to some encouraging changes in recent years, including the specific departmental interest at Health in encouraging research, notably Sir Keith Joseph's early decision to invest heavily in operational research, whilst the concern with management had percolated down the line. Nevertheless, Klein concludes "The difficult and important

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[1] R. Klein, Mismanaging the NHS, Management Today, December, 1971, p. 73.

decisions in the NHS - like the decision already taken to switch more resources to the care of the vulnerable - will always have to be taken on political rather than managerial grounds. The scope for improved management will lie rather in deciding how to achieve certain policy aims most efficiently"[1].

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[1] Ibid., pp. 73 - 5.

(B) The Influence of the Seebohm Report

The immediate starting-point of the re-organisation of the NHS can be identified as the setting-up of the Seebohm Committee in December, 1965, to consider the local authority personal social services. The work of this body was clearly likely to have implications for the NHS, and by October, 1967, the Ministry of Health was prepared to place a paper before the Social Services Committee of the Cabinet concerning the statement the Minister wished to make to the House of Commons about the proposed examination (within the Ministry of Health) of the possibility of re-organising the NHS. A long-term planning unit had been established in the Ministry of Health in February, 1967, with the question of re-organisation of the NHS specifically placed upon its agenda. Also, since October, 1966, the Health Programme Committee consisting of Treasury, Ministry of Health, Department of Economic Affairs and Scottish Home and Health Department representatives had been examining trends and problems in the hospital service. The Treasury was therefore in a position to understand the nature of the problems and to give support to the proposed statement.

However, it may be possible to clarify more precisely the starting-point of the re-organisation of the NHS. It had seemed that the Ministry of Health favoured the growth of health centres as the answer to the problems of co-ordination. Whereas 1946-64 had yielded only 21 health centres, 1964-66 saw a further nine opened, whilst a further 18 were being built, and in April, 1967, Mr. Kenneth Robinson

suggested that 400-500 centres could be functioning ten years hence[1]. Evidence given by the Ministry of Health to the Redcliffe-Maud Commission on the re-organisation of local government suggested that although the NHS needed to become more co-ordinated, it did not necessarily have to become more integrated physically[2]. Thus, at this time, the Ministry saw co-ordination, perhaps through some new piece of machinery, and integration through a re-organised structure, as two quite distinct things. Therefore, between the time of giving evidence before the Redcliffe-Maud Commission, and the establishment of the long-term planning unit in February, 1967, the Ministry of Health came to a firm conclusion that re-organisation, as opposed to co-ordinating machinery, was necessary.

The main reason for this conclusion may have come from knowledge of the likely recommendations of the Seebohm Committee. This Committee originally hoped to report six months after it was set up, i.e. in June, 1966. This proved impossible, but amongst the first to give evidence before the Committee was Professor R.M. Titmuss[3]. It is necessary here to examine the context in which the Seebohm Committee was established and the nature of the social work lobby with which it was associated[4].

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1 Lewis Gunn and Robert Mair, "Big Medicine for the Health Ministry", New Society, 20th July, 1967.

2 Royal Commission on Local Government, Minutes of Evidence of the Ministry of Health, 20th January, 1967. Evidence of Sir Arnold France.

3 15th April, 1966.

4 I am indebted to Mr. N.M. Thomas for much of the following information.

In 1964, the Kilbrandon Committee[1] had resulted in the setting-up of a working party of local authority representatives and civil servants, advised by Professor Titmuss, to work out proposals for the re-organisation of the local authority social services in Scotland. At the first meeting of the Seebohm Committee on 7th January, 1966, Mr. R. Huws Jones suggested it would be useful to draw on the experience of this Joint Working Group in Scotland. Eventually, a White Paper appeared in October, 1966, and ultimately the Social Work (Scotland) Act was passed in 1968. The provisions contained in these documents bear considerable resemblance to the Seebohm Committee's proposals, and in conjunction with the appearance of Professor Titmuss before the Committee, were of considerable influence. Thus, given the speed with which the Committee was trying to work, it is likely that the Ministry of Health became aware at an early stage of the probable trend of the Committee's thinking. This conclusion is reinforced by the personnel of the Seebohm Committee. Included in its membership were Mr. Huws Jones and Professor J.N. Morris, who were also members of the Long Term Study Group established by Mr. Robinson at the Ministry of Health in July, 1965. Also on the Seebohm Committee was Mrs. B. Serota, who shortly before the Committee reported, left to become Baroness in Waiting, and subsequently Minister of State at the Department of Health and Social Security with responsibility for the NHS. Dr. R.A. Parker, who acted as editor when the final report was written, was also at this

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[1] Report, "Children and Young Persons, Scotland", Cmnd. 2306, 1964.

time a member of Professor Titmuss's Department of Social Administration at the London School of Economics. Professor Titmuss was also a member of the Royal Commission on Medical Education with which the Ministry of Health was in touch. It can be seen therefore, that at the level of personal contacts, there was an abundance of opportunity for the Ministry of Health to establish the way the thinking of the Committee was likely to go.

It is worth noting the surprising absence of medical representation on the Seebohm Committee. In part this reflects the emergence of social work as a profession and its determination to rid itself of medical domination, particularly that of the medical officer of health who exerted effective organisational force on other professions such as nurses and ambulance officers, who, like social workers, wanted professional status in their own right. The membership of the Committee also purposely excluded those with a direct personal interest in a family service, including medical officers of health. However, two other factors were also responsible for the exclusion of medical representation. First, the terms of reference precluded the investigation of central government responsibilities, including those of the Ministry of Health. Also excluded was any review of the work of closely related fields outside local government such as hospital social work. The actual terms of reference were 'to review the organisation and responsibilites of the local authority personal social services in England and Wales, and to consider what changes are desirable to secure an effective family service'. This was taken to exclude any proposals for

removing any services from local government. Second, the medical profession failed to react to the appointment of the committee and does not seem to have pressed for any medical representation, and not until after the committee had reported did the British Medical Journal complain 'The absence from the committee of at least one medical officer of health and a family doctor is remarkable in view of its terms of reference'[1]. Certainly, during the two months following the announcement of the members of the committee, neither the BMJ nor the journal "Public Health" offered any comment. Partly, this may be explained by the medical profession's concern with the new deal for general practitioners arising out of the Annis Gillie Report[2], and partly by the low esteem in which the local authority medical service was held by the medical profession generally. In short, the medical profession simply failed to realise the potential importance of the establishment of the committee.[3] Thus, Professor J.N. Morris was left as the only medical member of the Seebohm Committee and he could scarcely be described as typical, and was known to have "iconoclastic views" about the roles of medical officers of health and community physicians.

On the nature of the social work lobby, it may be said that it derived from two principal sources. First, there was the Fabian/London County Council Children's Committee

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[1] British Medical Journal, 3rd August, 1968, p. 265.

[2] Central Health Services Council, Standing Medical Advisory Committee, "The Field of Work of the Family Doctor", HMSO, 1963. Report of the Sub-Committee.

[3] This was confirmed in an interview with Mr. Kenneth Robinson.

grouping, which was exerting pressure for the reform of the Children's Service, in the late 1950s. Influential in this group were Mrs. Audrey Callaghan and Mrs. Peggy Jay, who were on the Children's Committee of the London County Council. The view of this group in favour of enlarging the Children's Service into a "family service" was put forward by Professor D.V. Donnison and Mary Stewart in a Fabian Society pamphlet[1], and rejected by the Ingleby Committee.[2]

Second, there was the Association of Child Care Officers and the Association of Children's Officers, most of whose active members were social workers pressing for the development of the family service concept. The Child Care Officers in particular had links with the Labour Party. Mr. D.T. White was a prime mover in the Association of Child Care Officers, and professionally was in a senior position in the Lancashire Children's Department, the largest outside London, and had also been a Parliamentary candidate for the Labour Party.

Two other sources of the Social Work lobby may be noted. First, there were the academics, particularly at the London School of Economics, where the Titmuss/Donnison/Abel-Smith group were prominent. Dr. R.A. Parker, who became editor to the Seebohm Report, was a member of this group, and the influence of Professor Titmuss on the Joint Working Group in Scotland, and on the Seebohm Committee, has already been noted. Professor Donnison's contribution has been cited above, and Professor Abel-Smith was to have an important role as adviser to Mr. Crossman in the later stages of Labour's

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[1] Fabian Society, "The Child and the Social Services", 1958.

[2] This was the English equivalent of the Kilbrandon Committee in Scotland. Its report "Children and Young Persons" was published in 1960 as Cmnd. 1191.

attempt to re-organise the NHS when Mr. Crossman was ill.

Lastly, there were the civil servants on the Welfare side of the Ministry of Health, as against the Children's Department of the Home Office. The latter had been pressing for reform of the Children's Service, and were only prevented by a rearguard action by Mr. R. Huws Jones, Professor Titmuss, and the Welfare staff of the Ministry of Health, who wanted complete re-organisation of all local authority social services. They found, in Mr. Douglas Houghton[1], a ready recipient for their pressure. He had found himself in a difficult, almost powerless, co-ordinating role, and was able to seize upon this tp provide himself with a political power base[2]. This conflict was reflected in the composition of the Seebohm Committee, and the Home Office and the Local Authority Services Division of the Ministry of Health ensured that there was no medical representation[3].

One further point may be made about the background to the Seebohm Committee which may have given a clue about its likely recommendations. In 1963, the Longford Committee had been set up by the Labour Party to study the problem of crime, and had included both outside experts in the field of social work and a number of future Labour ministers, as well as Mrs. Serota, who was later to serve on the Seebohm

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[1] Chancellor of the Duchy of Lancaster with responsibility for co-ordinating social services.

[2] 796 H.C. Deb. 5s., col. 1485.

[3] Professor J.N. Morris represented social medicine, and could hardly be regarded as typically representing the medical profession.

Committee. The Longford Committee recommended that an integrated Family Service should be established by local authorities to take over the work of the Children's Departments, and the functions of Health, Education and Welfare Departments relevant to family problems. Reform along these lines seemed to be imminent when the Labour Government came into office in 1964, but concern began to be expressed that the proposed reforms were too narrow in scope, and might damage services for the mentally ill, physically handicapped and the elderly[1]. As a result of this concern, a memorandum was sent to Mr. Douglas Houghton, urging an inquiry into the personal social services before reform was undertaken, signed by a number of prominent members of the Social Work lobby[2]. The lobby was successful, and in the White Paper of August, 1965[3], notice was given of the intention to appoint a small independent committee to examine the organisation of local authority social services. The success of the Social Work lobby and its ideas of a strong social work department at local authority level meant, as Gunn and Mair point out, that ".... most of these ideas appear to accept that the price of co-ordinated social services is their virtual separation from the medical services"[4].

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1 R.M. Titmuss, "Social Work and Social Service: A Challenge for Local Government", Royal Society of Health Journal, Jan. - Feb., 1966, p. 21. This constituted the written evidence of Professor Titmuss to the Seebohm Committee.

2 See N.M. Thomas in R.A. Chapman, The Role of Commissions in Policy-Making, Allen and Unwin, London, 1973, p. 149.

3 The Child, The Family, and the Young Offender, Cmnd. 2742, HMSO, 1965.

4 New Society, 20th July, 1967.

This is reinforced by the written evidence presented by Professor Titmuss to the Seebohm Committee, where he says "What I am advocating is a sensible division of labour in the local 'community care' field which recognises that specialised skills should be related to specialised functions if specialised services are to operate effectively". He goes on to reject the case for Family Service Departments on the grounds that the proposal would be too family and child orientated, which might cause to be overlooked the needs of the elderly, the isolates and the mentally ill, and also on the grounds that the concept is not broad enough, and would mean that some important welfare responsibilities would remain outside the province of a Family Service Department. Also, he doubted whether a Family Service Department would bring together effectively within one administrative structure all the social workers in the employ of a local authority, with all the implications of this in terms of career and promotion prospects. He continues "These, in summary form, are some of the arguments for a structural re-organisation which places the emphasis on social service rather than on biological or sociological criteria - like the family - or on one element in the pattern of needs - like health or rehabilitation. We need departments providing services; not departments organised around categories of clients or particular fragments of need". The Association of Directors of Welfare Services reiterated this point when it published its evidence to the Seebohm Committee on 10th May, 1966, which advocated a single Social Service Department to take over health services with a high social

and low medical significance[1].

The Ministry of Health could, therefore, hardly fail to be aware of the way in which the thinking of the Seebohm Committee was likely to move. It is possible to go further and adduce evidence from the Seebohm Committee's minutes to support the proposition. At theSecond meeting of the Committee on 21st January, 1966, it was agreed that there was no objection to the Secretary keeping other government departments informed of the progress of the Committee's work. Documents submitted to the Committee on a confidential basis would have to be so treated, but other documents could be shown to government departments provided there was nothing in them likely to be embarrassing. The Committee would also be kept in close touch with the drafting of the White Paper (Scotland) and its legislative implications, and also on the progress of "Children in Trouble"[2] through Mr. Morrell in charge of the Children's Service at the Home Office.

The chronology of the development of the Committee's thinking up until February, 1967, as it appears in the minutes, can be traced as follows. Professor Titmuss gave his oral evidence on 15th April, 1966. At the meeting of the Committee on 13th May, Mr. R. Hews Jones reported to the Committee on the findings of a sub-committee established to consider the role of workers in Social Service Departments. Three broad categories were suggested forthis, (a) medical and nursing, (b) teaching, and (c) social work. Of these,

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[1] Department of the Environment Library: JS/3169/57/M62, Folder 72.

[2] Home Office, Children in Trouble, Cmnd. 3601, HMSO, 1968.

(c) was central to the inquiry, though there were overlaps with the other two categories. The basis of the classification was the kind of skill employed. When the Committee met representatives of the Home Office on the same day as this report, the division between physical health and social welfare as a basis, with each as a discipline in its own right, was emphasised by Miss J.D. Cooper of the Home Office. Thereafter, the Committee, often through Mr. E. Huws Jones, regularly asked for comments from those giving oral evidence on the relative merits of combined health and welfare departments and separated departments. The role of medical officers of health was also frequently raised at the same time. Thus, the Committee realised the significance of the possible connection between the two points at an early stage.

When the Committee met representatives of the Ministry of Health on 10th June, 1966, the Chairman opened the discussion by asking whether experience with existing patterns of organisation with some authorities having combined health and welfare departments and others having separate ones, offered any useful guidance on the difficult issue of the relationship between medical work and social work. In his reply, Sir George Godber expressed the view that in the existing situation combined health and welfare departments only worked well where the medical officer was prepared to allow the senior welfare officer freedom to decide major issues coming within the welfare officer's field of professional competence. He indicated that he would not like to see some of the present medical officers of health in charge of a combined health and social work

department. Mr. R. Huws Jones suggested in a question that there seemed to be three basic fields of professional competence involved in the Committee's inquiry: medical, educational and social work. As the medical department would always be handled by a doctor, he asked if there was not a good case for treating social work on the same basis. The Ministry representatives expressed reservations, and in summary concluded that a combined health and social work committee and a combined health and social work department would be in a strong position to attract first class members and chief officers and to lay claim to major shares in the distribution of resources. Clearly, the Ministry of Health representatives had not yet a clear idea of what the significance of the Committee's suggestions might be, though they acknowledged "that social work departments had to be substantially developed" and that "social work services and personal health services had to be deeply involved together, whether or not they were parts of the same Department". This meeting may well have provided the Ministry with the first clue as to what the possible outcome of the Committee's deliberations was to be, and its significance for the NHS.

On 29th July, representatives of the Council for Training in Social Work were questioned about the effect that their family welfare proposals would have on the functions of medical officers of health. In reply, Mr. R.C. Wright said that no estimate of the amount of work remaining to them had been made, but it was assumed a worthwhile field remained. Miss Geraldine Aves said that the Social Work Department could not work in isolation from

doctors but it would be more effective if it could use medical resources at all points and levels. Professor J.N. Morris on the Committee side suggested that General Practice developments meant that medical officers would have to adjust themselves to acting more in the role of providers of nursing support for General Practitioners rather than as supervisors of a large number of different services including social work services.

At the meeting of the Committee on 16th September it was reported that the Secretary of State for Scotland had agreed to make the next draft of the Scottish White Paper available to the Committee "probably within the next week or so". On the 11th November, a meeting was held between the Committee and Mr. R.E.C. Johnson and Mr. J.C. Johnston of the Scottish Home and Health Department, and Mr. I.A. Wilson of the Scottish Education Department. On the subject of the division between medical and social work, it was put to the representatives that the Scottish White Paper had been attacked on the grounds that it proposed the removal of all social work from the control of medical officers, and in particular, proposed the inclusion of mental welfare officers and psychiatric social workers in the new social work department. They replied as follows.

(a) The White paper was based on the principle that social workers had now built up a body of professional skills which could best be developed more effectively than others.

(b) Many medical officers in Scotland were in charge of welfare departments but there was no proof that these departments had been developed more effectively than others.

(c) The future role of Medical Officers of Health was being considered as part of the wider issue of the organisation of the health services which was at a preliminary stage of examination.

The latter remark accords with the general observation that developments in Scotland went ahead faster than in England and Wales, and that the SHHD showed a tendency to proceed with NHS re-organisation faster than the Ministry of Health in England, which was to cause the Treasury some concern.

The same queries were raised with the representatives of other bodies. On 4th November, Sir Charles Barratt for the Committee invited the representatives of the County Councils Association to comment on the argument that it was not sensible to divide medical from social work in a departmental structure. Mr. A.C. Hetherington, the Secretary of the Association, replied that "if there was a case for a united health and social work department there was also a case for a united health, social work and education department. This was thought to be impossible on grounds of size, if for no other reason. The medical qualifications provided, it was thought, a valid distinction between the health department and the social work department .... it was envisaged that in future there would be a closing of ranks with other branches of the health service, and in particular with general practitioners". He added that "it was more important that the three branches of the health service should be co-ordinated, than that the local health authority services should be in the same department as the local

authority social work services".

On the 25th November, the Committee met representatives of the Association of County Medical Officers of Health, and Mr. R. Huws Jones again raised the question whether there was any hard factual evidence of the relative advantages of combined or separate health and welfare departments. The response was to the effect that there was none except that there was a general movement towards combined departments. On the same day, representatives of the Association of Directors of Welfare Services and County Welfare Officers Society advanced their argument to the Committee in favour of all-embracing Social Service Departments, and indicated that they did not want the Medical Officer of Health as head, though a doctor might be. When asked what the future role of the Medical Officer of Health might be, Mr. J.T.Gregory (ADWS) said they would be faced with a serious situation unless hospitals were returned to local government. Mr. D.A. Schofield, President of CWOS, thought that the Health Department would still be viable, and that fresh fields might be opened up for medical officers if the work of the Royal Commission on Local Government resulted in the functions of Regional Hospital Boards and Executive Councils being transferred.

By the 14th February, 1967, the Committee was already in a position to make a provisional statement of its views on the re-organisation of the local authority personal social services at a meeting which was held with members of the Royal Commission on Local Government in England. As the Chairman, Mr. F. Seebohm, put it, "The weight of the opinions

expressed to them was in favour of a unified Social Service Department - that is, essentially, a unification of the present Welfare and Children's Services, perhaps with, and perhaps without, elements from the health and education departments. For the moment they were devoting their main attention to this possibility".

Finally, on 17th February, 1967, the Committee held a meeting with representatives of the Family Welfare Association, the Family Service Units, and the Invalid Children's Aid Association. Questioned about the future work of the medical officer by Mr. R. Huws Jones, Mr. Philp, Secretary of the Family Service Units, pointed out that the Family Service Units envisaged a vital continuing function for the medical officer as head of one of four federated departments. In the future, he thought it might be better to develop the personal social services on the basis of group practices with social workers attached to them; but they were nowhere near this at present. Miss Daniel, case-work consultant with the Family Welfare Association, suggested that the issue of the future of the medical officer of health could not be separated from the issue of the future of the tripartite structure of the NHS.

If, therefore, the Ministry of Health did indeed have made available the documents relating to the Seebohm Committee as the minutes of the second meeting of the Committee suggest, then clearly by the end of February, 1967, it would have received fairly clear indications of the way the Committee was thinking, and of its implications, particularly the politically crucial position of the Medical

Officers of Health. Further, it is known that two members of the Seebohm Committee informally and in a personal capacity met Mr. Robinson and privately informed him of the weight of evidence that was received by the Seebohm Committee and its implications for the Health Departments in local authorities. It was felt that he should be alerted so that he could consider any appropriate steps. Shortly afterwards, The Minister informed his Long Term Study Group that an internal study of re-organisation of the NHS had been set up, and subsequently the re-organisation draft paper was discussed by the group, though it was not given lengthy or detailed consideration[1].

The point becomes clear if the Seebohm Report and the first Green Paper[2] are taken in conjunction. What is politically crucial is that the Seebohm Report recommends that the new Social Service Department of local authorities should include the home help service; mental health social work services; adult training centres; other social work services and day nurseries, provided by local health departments[3]. Thus, Medical Officers of Health would have to hand over a considerable proportion of their departments, and it became a vital political task to transfer these important officers away from local government to a new structure with substantial responsibilities if the proposed re-organisation of the local government social services was to proceed

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1 Information provided in interviews with Mr. R. Huws Jones, Professor J.N. Morris and Mr. Kenneth Robinson.

2 Ministry of Health, The Administrative Structure of the Medical and Related Services in England and Wales, HMSO, London, 1968.

3 Para. 168, p. 51.

smoothly. The Society of Medical Officers of Health, in their evidence to the Seebohm Committee had rejected the notion of (a) all-purpose Social Service Departments, (b) Social Service Departments separate from Health and performing social work functions, and (c) Family Service Departments[1]. The Association of County Medical Officers of Health saw no need for new departments, or violent change, and thought some re-apportionment of services between Health and School Health Services would suffice[2]. Medical Officers of Health then, could not be expected to view the Seebohm recommendations with anything but concern. Thus, the Medical Officer of Health for Walsall thought radical changes in the organisation of personal social services would disrupt the NHS on the present tripartite basis and would jeopardise the whole NHS because of the relationship of the tripartite division[3].

It is not without significance, therefore, that the Seebohm Report makes reference to the role of the medical officer of health as the community physician. Paragraph 386 says "We therefore welcomed the announcement by the Minister of Health in November, 1967, that his department was to conduct an enquiry into the structure of the NHS. In dealing with the future of local medical services such an enquiry must pay particular attention to the medical officer of health - the community physician - and his team. The very

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[1] Department of the Environment Library: JS/3169/57/M62. Folder 173.

[2] Ibid., Folder 71.

[3] Ibid., Folder 55.

achievements of local health departments, the creation of the NHS, the new developments in the district general hospitals and in health centres, and changing medical and social needs have radically altered the nature of the task which now faces the community physician. Our own proposals involve further considerable changes. We therefore attach particular urgency to this aspect of the Minister's enquiry". Accordingly, the first Green Paper indicates the kind of responsibilities which it was felt should fall on the new area health authority. These included home nursing, health visiting, establishment of health centres, domiciliary midwifery services, the Child Health Service, the organisation and management of health care for the long-term sick such as the disabled, elderly and mentally disordered, vaccination, immunisation, family planning clinics, health education and the ambulance service[2]. Paragraph 32 says "Medical Officers of Health would then be able, as officers of the area authority, to extend their role as community physicians - specialists in community medicine. Their duties would include the epidemiological evaluation of the standards of health in each area". Medical Officers of Health were thus to be offered the twin benefits of divorce from the local government structure and professional integration into the NHS structure, together with wide-ranging and important responsibilities, as the price of the new Social Service Departments.

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[1] Paragraphs 383, p. 120 and 386, pp. 121 - 2.

[2] Paragraphs 25 - 31, pp. 13 - 14.

(C) The Influence of Local Government Reform.

The genesis of the reform of local government is to be found in the work of the Local Government Boundary Commissions for England and Wales which had been established in 1958 to recommend adjustments to the boundaries of local authorities within the existing structure. Richard Crossman as Minister of Housing and Local Government found that the terms of reference of the Commissions limited them to recommending only the kind of solutions "which merely tinkered with the problem". Crossman endeavoured to use the decisions he had to make on the recommendations of the Commission for England to make peace between the counties and county boroughs, but found his attempts to be "pretty futile" because "the conflict was inherent in the present structure"[1]. He had also found difficulties in dealing with the problems of relating the New Towns, with their existing Development Corporations, to the existing structure of local government and with the provision of services, including health services, to the New Towns. His predecessor, Mr. Robinson, had spoken of the possibility of experimenting with a unified health structure in New Towns[2].

Crossman therefore launched the theme of a radical reform of local government in a speech to the Association of Municipal Corporations at Torquay on 21st September, 1965, apparently without consulting either his officials at the

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[1] R.H.S. Crossman, The Diaries of a Cabinet Minister, Vol. I, Hamish Hamilton and Jonathan Cape, London, 1975, pp.439-40.

[2] The Lancet, 29 October, 1966, p. 958.

Ministry or his ministerial colleagues. He subsequently obtained approval for an inquiry into local government reform from the Cabinet on 27th January, 1966[1]. He was much impressed by the idea of city regions, and began to stress this in his public utterances. "In my speeches I began to break down the simple notion of the urban area on the one side and the country area on the other and to build up the idea of the city region, the urban area with the rural area attached to it for planning purposes[2]. This explains the presence of Derek Senior on the Royal Commission on Local Government in England as he was a leading exponent of the concept of city regions[3]. It may also explain the re-appearance of the region as part of the NHS structure proposed in the second Green Paper, albeit in shadowy form. Pressure for reform also came from other Whitehall ministries because they had to use local government for the execution of their plans including local economic development and urban renewal, and the machinery was frequently found to be ineffective[4].

The terms of reference of the Royal Commission restricted its consideration to the existing functions of local government. Nevertheless, when the first Green Paper was published, the Commission could scarcely ignore its possible implications for local government. The personal

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1 R.H.S. Crossman, The Diaries of a Cabinet Minster, Op. Cit., p. 439.

2 Ibid., p. 622.

3 D. Senior, "The City Region as an Administrative Unit", Political Quarterly, Vol. 36, No. 1, 1965, pp. 82 - 91.

4 J.P. Mackintosh, The Government and Politics of Britain, London, 1974, p. 182.

health services were an important part of the services provided by counties and county boroughs and the loss of these would be a severe blow to the status and prestige of local government, whereas if the NHS was transferred to local government, this would constitute a major reinforcement of its work. As Wood has pointed out, "If a new structure capable of accommodating the NHS could be created there would be pressure on the Government to move towards making the new local authorities responsible for the health service. If it could not, the chances of retaining the personal health services were slim"[1].

Derek Senior wanted to recommend that the hospital and general practitioner branches of the NHS should become a local government responsibility and felt there was no reason why the Commission should not do so[2]. Although legally he was correct, his colleagues felt that the danger was political, and compromised by speaking of the close links between the health and social services and stressed that the financial problem could be overcome if new sources of revenue were found for local government and that the traditional professional freedom of doctors and nurses would in no way be placed in jeopardy, thereby attempting to meet the major objections of those opposed to local government control of the NHS[3].

The Redcliffe-Maud Commission on Local Government in

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1 B. Wood, The Process of Local Government Reform, 1966-74, Allen and Unwin, London, 1976, p. 50.

2 Report of the Royal Commission on Local Government in England, Cmnd. 4040, 1969, Vol. 2, para. 287.

3 Ibid., vol. 1, paras. 359 - 67.

England may be said to have had both a positive and a negative influence on the re-organisation of the NHS. The positive aspect lies in the very fact that once Richard Crossman had determined to pursue a re-organisation of local government in 1965, then some change in the structure of the NHS was probable because, as the first Green Paper says "The aim should be to reduce the problem of co-ordination of different services to the smallest practicable dimensions and to arrange that the geographical areas of administration of the health services, if not the same as, coincide as far as possible with any new local government areas"[1]. This, however, was not necessarily the same as re-organisation of the NHS. Co-ordinating machinery might have provided the answer, as the evidence of the Permanent Secretary to the Ministry of Health to the Royal Commission on Local Government suggests.[2] It took the recommendations of the Seebohm Report to ensure that re-organisation would take place. To some extent, the establishment of the Royal Commission on Local Government may have been the cause of the internal departmental nature of the initial enquiry into the possibility of restructuring the NHS. Clearly, any proposals would have to be ready to be placed alongside those of the Royal Commission, if the need for co-terminous boundaries was to be met. This meant that the time for engaging the medical profession and other interested bodies in what might well be difficult and

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[1] Para. 24, p. 13.

[2] "I think there is need for (the NHS) to become more co-ordinated than it has been, but that of course does not mean .... that it need become more integrated physically". Evidence of Sir Arnold France, 20th January, 1967.

protracted consultations could be limited. The knowledge of the likely recommendations of the Seebohm Committee, and its relevance to Medical Officers of Health would add further urgency. When Mr. Crossman had originally grappled with reform of local government, he had envisaged proposals being brought forward by a small committee. In February, 1966 this was elevated to the status of a Royal Commission, with all the attached panoply involved, and it was not until 31st May, 1966 that the Royal Warrant was published. Clearly, this kind of delay would not be acceptable to the Ministry of Health, as it would allow the forces of opposition, always potentially formidable in the NHS, to gather. An internal enquiry and report would clearly have a better prospect of co-ordinating in terms of timing and recommendations with the Seebohm and Redcliffe-Maud enquiries. The fate of the proposed enquiry into the reform of local government may well have influenced Ministry of Health thinking on the kind of enquiry which was necessary. There was also essential consultation with the Treasury to be considered.

However, probably the most significant outcome of the Redcliffe-Maud Commission on Local Government was its negative influence. Its recommendations delivered the final death-blow to the proposals of the first Green Paper, which had already been subjected to considerable criticism. It is clear from the evidence presented to the Royal Commission by the Home Office, the Ministry of Transport and the Ministry of Housing and Local Government, that the majority of Government Departments concerned wanted 30 - 40 local government units. The Ministry of Health did not mention a

number of units, but spoke in terms of a preferred population of 150,000 to 250,000, which is not significantly different from the figures advanced by other departments. Only the Department of Education and Science wanted units of 500,000 population, or at least a minimum of 300,000[1]. The significance of this becomes apparent when in the first Green Paper, the number of area boards likely to be necessary is discussed. "These considerations suggest that each Board should cover quite a large area and serve a substantial population, and that the total number of Boards should not be large - perhaps about forty or fifty"[2]. The divided report of the Royal Commission, the majority of whom recommended 61 main authorities, whilst Derek Senior recommended a combination of 35 Regions and 148 Districts, meant that the Government's expectations had not been realised, and that both the reform of the local government structure and the NHS had to be re-thought. Ultimately, the second Green Paper, this time put forward by Mr. Crossman, who had originated the enquiry into local government reform, suggested that the number and the area of the new authorities would be co-incident with the new local government boundaries recommended by the majority Redcliffe-Maud Report, which the Government intended to introduce in a slightly modified form[3].

The re-organisation of local government did not itself necessitate a re-organisation of the NHS. Nevertheless, it

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1 Royal Commission on Local Government in England, Minutes of Evidence 1 - 5, 19th January to 27th February, 1967.

2 Para. 54, p. 19.

3 DHSS, National Health Service: The Future Structure of the NHS, 1970, para. 22, p. 8.

is an important strand in the development of the re-organisation of the NHS because first, it meant that some consideration had to be given at least to the adjustment of existing boundaries within the NHS, if not to more fundamental change. Second, once the shape of local government reform had been established[1], it became essential to ensure that there was a unit of administration in the NHS with boundaries co-terminous to those of the equivalent local government unit. This ensured the place of the area health authority in the re-organised NHS structure when it was placed alongside their reformed local government structure by the Conservative Government in 1973, in spite of objections that the NHS structure was arguably being given a tier too many with both regional and area health authorities[2] Local government reform had failed to produce a regional solution which would have provided opportunity for control of the NHS at the same level and thus the problem of co-terminous boundaries had to be solved at the county level by the provision of an equivalent area health authority with control exercised in the NHS through an additional regional tier.

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[1] By the Conservative White Paper, Local Government in England, Cmnd. 4584, 1971.

[2] House of Commons, Standing Committee G, 1972-3, cols. 317 - 328.

CHAPTER IV

The Role of the Central Department

The re-organisation of the NHS had two aspects when viewed at Central Government level. First, there was the need to establish a strong line of management accountability in order to make the NHS structure more responsive to centrally-determined policies, to contain the costs of morbidity and to obtain maximum value for money expended. This was the central concern of the Treasury. Second, there was the need for the Ministry of Health, later the Department of Health and Social Security, to make the kind of political compromises necessary to secure the co-operation of the various interested groups in making a re-organisation operative. This had to be reconciled with the objective of securing a strong vertical line of management accountability which was important to the Central Department as well as the Treasury. Nevertheless, the Department pressed less continuously on this point than the Treasury, doubtless because it was more aware of the difficulties entailed in dealing with the interested groups and of the necessity to reach solutions acceptable to them as it would have to continue to deal with them on a day-to-day basis.

It is not surprising, therefore, that the first Green Paper, produced within the Central Department under considerable pressure from the Treasury, and without outside consultation, was heavily 'managerial' in tone, and, indeed, was rejected by the doctors for this reason. The second Green Paper represented more of an attempt to accommodate the

wishes of the outside interests and showed less regard for vertical lines of management accountability, preferring to rely on a greater degree of democratic participation to secure responsiveness within the NHS. The Conservative White Paper attempted to take into account both problems, and effectively distinguished between the problem of securing strong vertical lines of control and that of providing for effective co-operation between the interested groups which involved lateral re-organisation. The vertical re-organisation was largely carried out by statute and the horizontal re-organisation through the medium of two working parties, one on the management arrangements for the re-organised NHS, and the other on collaboration between the NHS and local government, with the recommendations largely carried through by regulation. Thus, a progression of proposals can be traced with, first of all, the problem of the interest groups being largely ignored and with the influence of the Treasury relatively strong. This was followed by proposals which reflected more closely a desire to find a solution tolerably acceptable to the interest groups and which found the Department in conflict with the Treasury. The final proposals reflected a greater degree of co-operation between Department and Treasury, and paid less heed to the interest groups, whose basic positions were well known, attempting to meet these where necessary by provision for representation within the NHS structure and for co-operation between the NHS and local government structures, secured independently of the vertical re-organisation.

When Mr. Kenneth Robinson became Minister of Health

in October, 1964, there was no indication that he had in mind a fundamental re-organisation of the NHS, although he was "vaguely aware that the NHS structure was creaking and that it was time to have a look at it". There were two reasons why this was not done immediately. First, there were too many pressing problems such as those surrounding General Practice at this time. Second, Mr. Robinson thought that the structure could work and did work in a very limited number of areas because individuals were determined to make it work in co-operation with other individuals, and he hoped these situations could be multiplied[1].

Some indication of the trend of Mr. Robinson's thinking might be gained from an article he published in February, 1964[2]. He suggested that a future Labour government would give further encouragement to Group Practice by the use of government loans, and would try to increase "the woefully small number of Health Centres established in the last fifteen years". He continued

> "It will be necessary to improve liaison within the Health Service by bringing the three branches - hospitals, local authorities and executive councils - closer together. I am confident that this can be achieved without recourse to the drastic solution recommended by the Porritt Committee, namely the setting up of Area Health Boards, which would involve the winding up of Regional Hospital Boards and Executive Councils as well as the removal of personal health services from the local authorities. Nor is it likely that Area Boards themselves would solve the problems of co-operation and liaison between the different types of service. This is not to say that some changes in the administrative structure might not be found necessary by a Labour Government, but these would take a less

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[1] Information provided by Mr. Robinson in an interview.

[2] K. Robinson, "Labour and the NHS" in Socialist Commentary, February, 1964.

"radical form than the Porritt proposals"[1].

However, Mr. Robinson became gradually disillusioned about the possibilities of improving co-operation in the existing situation and decided after two years that "this was something that should be looked at". Therefore, he turned two of his most intellectually capable advisors[2] to looking at the possible alternatives and he held periodic meetings at which ideas were discussed, and it was from these meetings that the first Green Paper grew. The original concept was to get an all-purpose authority and to remove a tier from the structure so that attention came to be focussed on the notion of 40 - 50 Area Health Boards responsible directly to the Ministry of Health. One criticism of the existing structure was its undemocratic nature and Mr. Robinson himself thought the best way to meet this criticism was to include a proportion of local authority representatives on Area Health Boards. "It was optimistically thought at this time that the quality of local government would be improved by re-organisation"[3].

Another aspect of Mr. Robinson's approach to the possibility of integration in the NHS was the formation of his personal long-term study group. Early in his tenure of office he announced he was looking for suitable areas where

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1 Ibid., p.9.

2 Mr. W.D. Pile and Mr. T.E. Nodder. They headed a team which remained in continuous existence until the passage of the NHS Act in 1973. At its largest it numbered 19, including an Under-Secretary, two Assistant Secretaries and three Principals. See F. Stacey, British Government 1966-75, Oxford University Press, London, 1975.

3 I am indebted to Mr. Robinson for allowing me a most valuable discussion on the origins of NHS re-organisation, and for providing this information.

all three branches were prepared to work together on co-ordinated and comprehensive plans. This was followed by the establishment of this informal advisory group to examine long-term aspects of the service with particular reference to the interaction of its parts. This was the Minister's personal group, which he himself chaired, and which was attended by the Permanent Secretary. This group was primarily intended as a forum for airing ideas about the future of the Health Services, and particularly their relationship with the Welfare Services. A particular need which came to be identified in the course of discussion was that for "inter-face" between the two services, and this particular term came to be much employed in the discussions that took place within the group. However, the group never discussed the re-organisation of the structure of the NHS directly, and the subject arose only tangentially in the discussions[1]. The proposals of the first Green Paper therefore owe nothing directly to this group, but undoubtedly its discussions did much to prepare the way for a recognition of the need for re-organisation at least at Ministerial level. In fact, it was two members of this group who were also members of the Seebohm Committee who alerted the Minister personally and informally to the direction in which the evidence to the Seebohm Committee was leading, and its significance for Health Departments in local authorities, in order that he might consider any appropriate steps. Subsequently, the long-term study group did discuss the

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[1] Information supplied by two members of the group, Mr. R. Huws Jones and Professor J.N. Morris.

draft of the re-organisation proposals, although the consideration it was able to give to the proposals was neither lengthy nor detailed.

In 1966, therefore, Mr. Robinson began to express interest in the Area Health Board concept and indicated that he hoped to have the power to experiment with that type of organisation when new legislation was introduced, though he did not give the medical profession any indication that they would be given the control over the Area Health Boards the Porritt Report had suggested[1].

Further indications that the Minister would have preferred accommodation of evolving services within the existing framework to wholesale changes is suggested by the terms of the Ministry of Health's evidence to the Royal Commission on Local Government in England[2]. The evidence assumes the continuance of the three branches of the NHS. It suggested that existing county borough and county areas could be re-arranged to include both towns and surrounding country areas with populations of at least 200,000, and that such areas could coincide more closely with the catchment areas of Hospital Management Committees, and this would improve contact between local government and the three branches of the NHS[3].

Ryan suggests that the Ministry envisaged the continuance of the tripartite structure, but wished to

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[1] The Lancet, 29 October, 1966, p. 958.

[2] M. Ryan, Reform of the Health Service Structure in Public Administration, Autumn, 1968, pp. 329-30.

[3] Written evidence of the Ministry of Health, RM30, 1967, paras. 10, 29, 30.

provide a more rational distribution of functions within it[1]. Thus, it was pointed out to the Royal Commission on Local Government in England that there was a strong case for transferring the ambulance service from local authorities to the hospital service[2]. Similarly, the Ministry's evidence to the Royal Commission on Medical Education suggested that

> "Many of the functions which are at present undertaken by local health authorities almost as a separate arm /...../ are likely to be more effectively discharged if they are undertaken by the family doctor assisted by the staff of the local health authority working together as members of a domiciliary team"[3].

However, by the time Mr. Robinson gave his Maurice Bloch Lecture on 6th December, 1967, this position had changed, and the Minister took the opportunity to indicate the trends which had brought about this change[4]. He pointed to two main developments. First, there was what he termed "the Revolution in General Practice". By this he meant the growth of group practice coupled with access to and use of hospital diagnostic support facilities; the concept of the General Practitioner as leader of a team of health visitors, home nurses and midwives, as was being tried out at Oxford; and the upsurge of interest in health centres. As the Minister saw it, the structure had to be made to suit the needs of those doing this work. Second, there were the developments in medical technology, not only in brain and heart surgery, but in management of health planning, such as

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[1] M. Ryan, Op. Cit., p. 330.

[2] Ibid.

[3] Appendix 2, para. 25.

[4] K. Robinson, Partnership in Medical Care, University of Glasgow, 1968.

the techniques of operational research, standardised components for new hospitals, and the standardisation of supply items and procedures. The problem was to attain a management/medical optimum and at the same time retain a concern for humanity and personal contact. Mr. Robinson also predicted a rapid functional linking of the hospital and community services. Thus, the Minister in this lecture revealed the extent of his department's concern for questions of management.

In part, at least, this concern for questions of management arose from the discussions in the Health Programme Committee between the Treasury and the Ministry of Health, where it was found to be difficult to support the wide variations in costs which the tripartite system appeared to encourage. It is also, perhaps, a question of administrative style. It is interesting to note that the proposals Mr. Robinson was to put forward in 1968 were rejected by the BMA as too managerial[1], although the Conservative plan of 1972, which arguably placed even greater emphasis on management, was subsequently accepted. The continuity contained in the successive DHSS proposals for the re-organisation of the NHS may indicate that these proposals were very much in keeping with the emerging Civil Service style of the late 1960s. "It is the style of the Fulton Report, and its emphasis on a more managerial approach. It is the style of the subsequent changes in the methods of the Civil Service. The language and the approach is the same, suggesting the

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[1] British Medical Journal, 8 February, 1969, pp. 329-330.

importance of the intellectual environment in which policy-making takes place"[1].

The establishment of the long-term planning unit in February, 1967 was no doubt bound up with the wish of the Ministry to retain the examination of the structure of the NHS as an internal inquiry, without engaging at this stage in outside consultations, in contrast to the SHHD, which did. However, one important reason for retaining the inquiry internally was the need to tie in the proposed review with the activities of the Royal Commission on Local Government, due to report at the end of 1968, as the proposed review would cover the local authority health services, and could have concluded, for example, that those services might be removed from local government and placed elsewhere. The Ministry of Housing and Local Government would certainly have objected to any kind of outside inquiry, as the publication of proposals before the Royal Commission published its report, and would have wanted to reassure the Royal Commission that no final decision would be taken on the review as it might affect local health services until the government had received the Royal Commission's report. It would clearly be desirable that any necessary reconciliation between proposals to re-organise the NHS and the work of the Royal Commission on Local Government should take placebefore the work of the latter wastoo advanced. It would clearly be undesirable to have two inconsistent sets of proposals alongside each other, and this probably meant proceeding with the internal

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[1] R. Klein, "Policy Making in the National Health Service" in Political Studies, March, 1974, p. 11.

review of the NHS very rapidly, so that any proposals would be available to the Cabinet by the Spring or Summer of 1968, in order to assist any necessary reconciliation. The Treasury would no doubt also have favoured an internal inquiry as enabling it to influence the thinking of the Departments, and to point them in the direction of improving the efficiency of management as much as towards organisational integration.

In examining the first Green Paper, the influence of a number of these factors may be traced. The proposal for 40-50 Area Health Boards was linked with the number of major local authorities that the Royal Commission on Local Government were thought to be likely to propose. It also tied in with the number of District General Hospitals planned at this time. The provision for complete financing of the Area Health Boards by the Exchequer was clearly influenced by Treasury thinking on the need to exclude local government from management of the NHS. Similarly, a slight gesture was made to the option of integrating the NHS under local government, but no provision was made for pursuing this, whilst any implication that local authorities had a right to some degree of membership on Area Health Boards was removed by Cabinet decision. This is surprising in view of the fact that local authorities might be required to give up some of their health services, subject to the recommendations of the Seebohm Committee. However, no doubt this reflected the Treasury view that if any specific level of membership on Area Health Boards was offered to local authorities, this would be used as a base from which to bargain upwards. It also reflected

what was known of the Seebohm Committee's thinking concerning the division of the health and social services on the basis of the skills involved.

In the event, comments on the first Green Paper revealed overwhelming support for a two-tier structure, though they were divided on whether this meant districts below Area Health Boards, or large regions over areas, or regions over districts, and this doubtless reflects as much conflict of terminology as of intention. Regional Health Boards took a unanimous view that the Green Paper areas would be too small for planning and too large for management, and argued in favour of 15 - 20 upper tier authorities[1]. Boards of Governors and Hospital Management Committees also favoured a two-tier structure, the former supporting either regions over areas or over districts, whereas the latter preferred a tier at district level. Another major criticism was the inadequate provision for participation and democratic representation in the proposed authorities.

There was also another fundamental doubt, which was raised by Anne Lapping. It was argued in this article that the Ministry of Health was giving up territory in return for power, i.e. control of local welfare functions in order to bring local authority health services within central control through area health boards, and thereby to take over that area where it was relatively weak and where variations in standards were greatest. The doubt arose because "Problems of co-ordination were partly responsible both for the Seebohm

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[1] R.H.S. Crossman, The Diaries of a Cabinet Minister, vol. III, Op. Cit., p. 329.

Committee's suggestions and for the area health board proposal. How certain can one be that the long-term sick, the disabled and the elderly will not again find themselves the losers because responsibility for their welfare will devolve on two departments instead of several as previously? How, in institutional terms, will the lines of communication be kept open between a board that is concentrating on medical factors, and a social work department that may, at the beginning at any rate, pride itself on its new-found self-sufficiency?"[1].

Mr. Richard Crossman assumed the office of Secretary of State at the newly-formed DHSS on 1st November, 1968. At an early stage he rejected the suggestions for re-organisation put forward in Mr. Robinson's Green Paper. This became clear at a conference of RHB chairmen and officials on the Green Paper which he chaired on 17th January, 1969, and where he found unanimous opposition to the one-tier proposal. He noted

> "My civil servants were sitting behind me as I ruled out the Green Paper in one stroke. If that is the view of the RHBs, just imagine what the doctor's Executive Council or the local authorities will say. These RHBs were the only people who could have supported the Robinson plan and they had rejected it. It was amazing that the Ministry could have put it up".

Mr. Crossman commented upon the "twenty huge areas run by sixteen oligarchs responsible to London", which he claimed to know the Department really wanted, that "It was the most astonishing piece of misjudgement of public opinion to think that such a recommendation could go through"[2]. In his

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[1] Anne Lapping, "A New Health Service" in New Society, 25 July, 1968, p. 115.

[2] R.H.S. Crossman, The Diaries of a Cabinet Minister, volume III, p. 329.

outside consultations therefore, Mr. Crossman was at pains to assure people that the question was really open to discussion[1].

However, it may be argued against Mr. Crossman's view that the RHBs, who were the first bodies he consulted on the Green Paper, were precisely the element most likely to oppose its proposals as heralding their own abolition. It might also be argued that Mr. Robinson, who, it was recognised, had done much to save General Practice from collapse, might have persuaded the doctors to accept what his successors could not. It could be said that the case for the first Green Paper simply went by default in the sense that there was no-one to argue for whatever merits it might have had, as Mr. Robinson had moved to the Ministry of Housing and Local Government[2].

There were two basic reasons behind Mr. Crossman's rejection of the first Green Paper. First, there was the widespread criticism of the one-tier structure mentioned above. Second, there was the personal antipathy felt by Mr. Crossman for the suggestions contained in the Green Paper. This arose to some extent from Mr. Crossman's local government background which contrasted with Mr. Robinson's NHS experience[3]. Mr. Crossman wanted to see some form of increased public representation and participation in the NHS structure whereas Mr. Robinson, who was regarded within the NHS as an excellent Minister of Health in conventional terms

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1 County Councils' Association Gazette, November, 1968, p.319. It must be borne in mind that the Green Paper concept was a new one (this was only the second to be published) and was not fully understood at this time.

2 These views were expressed by Mr. Robinson in an interview.

3 He had been a member of a Regional Hospital Board for nearly fourteen years.

"was not a fundamental re-organisation man. He was very much a staff man".

Mr. Crossman's ideas on NHS re-organisation owed more to outside consultations with the interests concerned than to the Department internally. Mr. Robinson's Green Paper had been one of the first fruits of the long-term planning unit[1] assisted by a departmental working party, and had largely been written by the Permanent Secretary, Sir Arnold France. Mr. Crossman depended to a far greater extent upon his personal adviser, Professor Brian Abel-Smith, and Mr. Paul Odgers, in charge of Mr. Crossman's co-ordinating staff[2]. Three considerations influenced Mr. Crossman's approach to his own Green Paper. First, there was the need, as Mr. Crossman saw it, to strengthen central influence on policy within the NHS, a need which was highlighted by the Ely Hospital scandal. Second, there was the need to provide for some form of public representation and participation. Third, there were problems arising from the timetable for publication of the Green Paper which had to be fitted in with the timing of Government decisions on the recommendations of the Seebohm Committee and on the expected recommendations of the Royal Commission on Local Government.

The need for greater central influence on policy struck Mr. Crossman early in his period of office when the plight of chronically-ill patients in long-stay hospitals

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1 J.R. Butler and R.J.C. Pearson, "The Future of the NHS", Political Quarterly, January - March, 1969, p. 37.

2 Brian Abel-Smith. Professor of Social Administration at LSE since 1965 and Senior Adviser to the Secretary of State for Health and Social Security, 1968-70.
Paul Odgers. Joined Mr. Crossman in 1968 and moved with him from the Lord President's Office to the DHSS, where he was in charge of the co-ordinating staff.

was brought vividly home to him, and this theme constantly recurs in his Diary for this period[1]. Prior to Mr. Crossman's assumption of office there had been mounting comment on the condition of patients in some long-stay hospitals. The most sensational allegations had been made about six such hospitals for old people by Mrs. Barbara Robb[2]. Mr. Robinson had responded by ordering committees of inquiry to investigate all six hospitals and publishing their reports. He told the House of Commons that these committees had found most of the allegations to be totally unfounded and grossly exaggerated[3]. Mr. Crossman commented,

> "I feel he has done nothing whatsoever to silence Mrs. Robb because the bare picture is not terribly convincing .... the public relations of the Ministry of Health are terrible. It has an appallingly bad press office and really faulty relations with the general public"[4].

As a result, Mr. Crossman used the Ely Hospital scandal to establish the Hospital Advisory Service and made strenuous efforts to obtain some switch in resources from the acute to the chronic sector on the part of the RHBs. In this, he was not entirely successful, and Klein has indicated the reason for this.

> "He failed but not because the medical profession acted as an organised pressure group to stop him; there were no protests from the BMA, no campaign by the organised medical interests. It was, however, made clear to Crossman by his civil servants and by the chairman and officers of the regional hospital boards that a diversion of existing resources was

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1 See Volume III, pp. 140, 177, 188, 195, 389, 408, 410, 413, 418, 419, 429, 430, 436, 455, 456, 486, 489, 608, 613, 726, 727, 814, 859, 943.

2 Barbara Robb, Sans Everything, Nelson, London, 1967.

3 768 H.C. Deb. 5s., cols. 213 - 6.

4 R.H.S. Crossman, The Diaries of a Cabinet Minister, volume III, Op. Cit, p. 134.

> unacceptable to the profession. And since the profession formed part of the fabric of the NHS - since it is represented at all the administrative levels of the organisation as well as being responsible for the delivery of the service - he had no option but to abandon his attempt"[1].

One other incident brought home to Mr. Crossman the lack of central influence on policy. He recorded how he tackled Dr. Elizabeth Shore who was in charge of the campaign at the DHSS to increase the rate of return to general practice of married women doctors. She told him,

> "It's no good, we are doing everything perfectly all right. There is no more we can possibly do. Publicity and administrative memoranda don't have any effect. We have to do it through our personal relations between the doctors in the Ministry and the doctors in the regions but most of the regions will do nothing because they don't pay attention to us".

Mr. Crossman responded, "You know, what you are really saying is that our job of advising the regions doesn't have any influence" - and received the reply "I don't deny that"[2]. The effect of experiences such as these on Mr. Crossman was to increase his determination to make the NHS more responsive through an injection of popular representation into the structure, in opposition to the Treasury view that 100 per cent Government appointments and line managers at regional level would serve this purpose best.

The provision of greater public representation in the NHS was to cause Mr. Crossman considerable difficulty. At an early stage in his thinking, Mr. Crossman rejected placing the NHS under local government control as a solution

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[1] R. Klein, "Policy Problems and Policy Perceptions in the National Health Service" in Policy and Politics, March, 1974, pp. 226 - 7.

[2] R.H.S. Crossman, The Diaries of a Cabinet Minister, Volume III, Op.Cit., p. 370.

to this problem. On 25th April, 1969, he wrote to Mr. Anthony Crosland[1] indicating that the opposition of the doctors and difficulties in organising appropriate financial arrangements precluded this solution[2]. He then considered having powerful regional executives and a district level with popular participation[3]. He was encouraged in this by his discovery that joint Local Authority Associations/BMA meetings had assumed that there would be an independent NHS with considerable local government representation at district level, and he therefore proposed that the composition of the regional and district authorities should consist of one-third Ministerial appointees, one-third representatives of the medical professions and one-third local government representatives, and forced this through the Social Services Committee of the Cabinet in the teeth of Treasury opposition which insisted first, on 100 per cent Ministerial appointees, and subsequently on a minimum of 51 per cent of such appointees[4]. Mr. Crossman's composition was kept when consideration of the Redcliffe-Maud proposals for local government reform forced Mr. Crossman to substitute Area Boards for regions and to make Health Districts parallel to Redcliffe-Maud Districts with regions kept for specific functional purposes such as postgraduate education, ambulances and the supply of blood[5]. He hoped also to satisfy the Treasury demand for stronger central control

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[1] Secretary of State for Local Government and Regional Planning, 1969-70.

[2] R.H.S. Crossman, The Diaries of a Cabinet Minister, volume III, Op. Cit., p. 456.

[3] Ibid., p. 607.

[4] Ibid., p. 673.

[5] Ibid., p. 692.

through regional offices[1]. This new proposal he successfully steered through the Social Services Committee and Cabinet, where he first obtained a decision that the NHS would be re-organised outside local government and that area authorities would have the same boundaries as the proposed unitary local government authorities and then at a subsequent meeting pushed through his proposals on composition in the face of Treasury opposition[2]. This was the form in which the second Green Paper was published.

The problem of the timetable for publishing the second Green Paper arose from its relationship to the recommendations of the Seebohm Committee and to those of the Redcliffe-Maud Report on the reform of local government and because, as one participant put it, "they came from separate stables and were only put together at the end". The difficulty came about because the Seebohm Report had been published in July, 1968, but the publication of the Redcliffe-Maud Report had been delayed until June, 1969[3]. Mr. Crossman therefore came under pressure to implement the Seebohm Report which would entail establishing the dividing line between social services and health at local government level. However, in order to do this, which would require legislation in the next session of Parliament, he had to consider whether the social services should undergo immediate re-organisation and then face a second re-organisation if the Redcliffe-Maud Report

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[1] Ibid., p. 773.

[2] Ibid., pp. 781 - 2 and 784 - 5.

[3] Report of the Royal Commission on Local Government in England, (Redcliffe-Maud, Ch.), Cmnd. 4040, 1969.

were to be implemented. If this were to be done, Mr. Crossman also had to find some way of pacifying the doctors by announcing that the NHS would not come within local government. On the other hand, if he did not implement Seebohm quickly, it would mean that the integrated social services would probably come under the medical officers of health, which would amount to a repudiation of Seebohm. Equally, if it was announced that the NHS would not come under local government, Mr. Crossman would be accused of pre-judging the outcome of the Redcliffe-Maud Report. A further problem was that if legislation was introduced on Seebohm lines, then the dividing line between health and social services would have to be considered, and this came vividly to Crossman's attention when he was confronted by the draft Cabinet Committee paper recommending the lines of the Bill implementing Seebohm, drawn up by Mr. Odgers[1].

The solution to the problem was eased by Mr. Crossman's discovery that the discussions between the local authorities and the BMA had assumed that the NHS would be outside local government[2]. This meant that he could announce that the NHS would be outside local government, assure the local authorities and the BMA that they would get a large number of representatives in the new structure and that the dividing line between health and social services could be discussed. The next phase of the solution then became the establishing of the composition of the health authorities as outlined above.

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[1] R.H.S. Crossman, The Diaries of a Cabinet Minister, volume III, Op. Cit., p. 775.

[2] Ibid., p. 633.

Subsequently, the Redcliffe-Maud Report, and the decision to accept it with minimal changes, caused Mr. Crossman to revise his ideas in order to have a top tier of sixteen regions and seventy or eighty second-tier bodies as the equivalent of Redcliffe-Maud's unitary authorities. He was warned, however, that there was tremendous opposition to this on the grounds that the scheme would be as remote from the grass-roots as ever. Mr. Crossman then proposed to remove the regional tier altogether and have just Area Boards and District Committees, with the latter reporting directly to the Area Boards and the Ministry. There would be no intermediate body except for regional consortia for specific purposes. Discussion with the Ministry convinced Mr. Crossman that he could not remove the regional tier altogether as it would be required for specific functional purposes, but that he ought to put all the power into the Area Board and to make the District parallel to the Redcliffe-Maud District[1].

This, then, was the proposal that Mr. Crossman was able to discuss with the BMA on 22nd December, 1969[2]. Subsequently, on January 3rd, he realised that the solution to his timetable problem was at hand[3]. As he had now established that the NHS was to be re-organised outside local government (which had not been the case back in September), it was now possible for the dividing line between health and social

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[1] Ibid., p. 753.

[2] Ibid., p. 758.

[3] Ibid., pp. 775 - 6.

services to be determined by the Seebohm Bill, which meant that it did not have to appear for discussion in the forthcoming Green Paper at all and that publication need be delayed no longer. It had been announced in the Queen's Speech on October 28th that proposals relating to the Seebohm Report would be brought forward when the Government had made its decision on local government reform towards the turn of the year. The decisions on local government reform were made during November and announced in the White Paper on 4th February, 1970[1].

The inter-weaving of these three main problems determined the outcome of Mr. Crossman's deliberations on the content of the second Green Paper. Arguably, it was a very adept political compromise which was achieved by retaining many identifiable elements in the existing structure in order to limit opposition. As one commentator put it,

> "To the disinterested observer, the Crossman Green Paper looked like the perfect political compromise which, by abandoning the radicalism of its predecessor and retaining much of the existing structure in all-too-recognisable form, had succeeded in appeasing all conceivable interests to the maximum possible extent"[2].

Sir Keith Joseph arrived at the DHSS in circumstances where he had not been in charge of Conservative social policy whilst in Opposition, and had expected to be appointed to the Department of Trade and Industry[3]. This meant that while in some areas of policy, such as those relating to health

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[1] R.H.S. Crossman, The Diaries of a Cabinet Minister, Volume III, Op. Cit., pp. 733 - 4.

[2] R.G.S. Brown, "Re-organising the Health Service" in K. Jones, The Year Book of Social Policy in Britain, 1971, Routledge and Kegan Paul, London, 1972, p. 124. Less charitably, the proposals were described by a previous Minister of Health as "appeasement".

[3] Information provided in an interview by Mr. R. Klein.

service charges, he was unprepared for the problems, in other ways he was able to take a fresh look at the NHS unencumbered by previous discussions and pronouncements. At the beginning of his term of office, his department took part in an intensive investigation into the NHS by an inter-departmental committee chaired from the Treasury. This investigation stemmed from two opposed attitudes, namely the desire of Sir Keith Joseph to inject more funds into national provision for health, and the desire of the Treasury to limit the Exchequer's and the taxpayers' liability[1]. However, in the event, nothing ultimately seems to have emerged from this committee in terms of hard decisions. It does, however, indicate Sir Keith's willingness to look at a wide range of possibilities in order to obtain the additional money needed by the NHS to provide for those areas such as the elderly and mentally ill where the need was greatest.

In fact, there was a close accord between Sir Keith Joseph at the DHSS and Mr. Barber as Chancellor of the Exchequer and Mr. Maurice Macmillan as Chief Secretary. The attitude of Sir Keith to the problem of financing government spending was matched by the sensitivity shown by Mr. Barber (a former Health Minister) and Mr. Macmillan (who was partly responsible for Conservative health policy in Opposition), to the aims of Sir Keith.

This is indicated by the extra £250 million made available for the services concerned with the elderly and the mentally ill by the Government between the election of June, 1970 and December, 1971. This sum was earmarked for

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[1] The Times, 21 December, 1970.

this purpose and had nothing to do with capital or running costs[1].

Another significant factor was the re-organisation of the structure of the DHSS. The team responsible for this was established late in 1970 and reported in June, 1972. It consisted of officers of the Department, one officer from the Civil Service Department and consultants from McKinsey and Company under the guidance of a Steering Committee chaired by the Permanent Secretary. Three factors contributed to the decision to reconsider the organisation of the DHSS. First, there was the decision to integrate the three branches of the NHS. Second, there was the integration of the administration of the personal social services in the recently created social service departments of local authorities. Third, there was the enlargement of the Department itself by the merger of health with social security

The re-organisation differed significantly from the previous structure in five main ways.

(1) There was to be a substantial strengthening of the geographic element in the organisation, particularly on the health side, with the establishment of Regional Divisions.

(2) There was to be a move away from service demarcations as the main basis for organisation. In future, two Services Development Divisions would be organised to identify the needs, and propose the best way to meet them by any combination of services, of certain client groups

> "who at present occupy more than two thirds of hospital beds and local authority residential

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[1] The Times, 25 November, 1971.

> places and account for half the total costs of the health and social services. Policy in relation to these client groups should not be, and will not be, constrained by service boundaries. Moreover, the Department will in future be able to use the client group mechanism to give special attention to any client group, and the Regional Divisions will help the Secretary of State to guide the development of the personal social services and health services in a co-ordinated way for the benefit of the people they serve"[1].

(3) Professional and administrative organisations were to be designed more closely in relation to the work structure.

(4) All work on pay and conditions of NHS personnel was to be passed to Personnel Divisions, including that done by the existing Executive Councils Division.

(5) There was to be increased emphasis on research and planning with the establishment of a Planning Committee and a new Planning Operational Research and Research Administrative Division[2].

Thus, the central management of the health services in relation to the re-organised NHS structure was already under consideration prior to the publication of the White Paper, and the emphasis on the regional tier, on the continuing separate provision of Executive Council functions, on planning and on provision for the chronic sector may all be significant.

It is scarcely surprising, therefore, that Sir Keith in his Consultative Document should have taken the view that "the importance of good management in making the best use of

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[1] e.g. the mentally ill, the elderly, the socially deprived.

[2] DHSS: The NHS in Relation to the Health and Personal Social Services: Review Team Report, Summary, June, 1972, pp. 2.5 - 2.6.

resources can hardly be overstated". The basic difference between this document and earlier proposals was "the emphasis (placed) on effective management"[1].

The Consultative Document kept the Area Health Authorities based on the boundaries of the counties and the metropolitan districts proposed for local government, and this meant that there would be about 70 Area Health Authorities outside London. Emphasis was laid on the need to ensure effective co-operation and co-ordination between the Area Health Authorities and the local authorities[2]. The functions of the Regional Health Authorities were greatly extended compared with the second Green Paper, and they were to take on responsibility for the general planning of the NHS, the allocation of resources, and the co-ordination of services between areas. The boundaries of the Regional Health Authorities were to be the same as in the second Green Paper, so the number remained unchanged at 14, i.e. the planning regions hitherto adopted for the hospital service[3].

However, the Consultative Document departed significantly from the second Green Paper in the membership of the authorities. The emphasis on the need for efficient management dictated that "the authorities (would) be kept small and management ability (would) be the main criteria of the selection of members"[4]. This meant that the representational

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[1] DHSS National Health Service Re-organisation: Consultative Document, 1971, p. 2.

[2] Ibid., paras. 7 and 8, pp. 6 - 7.

[3] Ibid., paras. 9 and 10, pp. 7 - 8.

[4] Ibid., para. 14, p. 9.

basis put forward in the second Green Paper had to be changed, and therefore the Chairman and all members of the Regional Health Authorities would be appointed by the Secretary of State after consultation with interested organisations, whilst Chairmen and members of Area Health Authorities would be appointed by the local authorities and the Regional Health Authorities in consultation with interested organisations, with one member to represent the relevant university[1].

A further difference between the second Green Paper and the Consultative Document was that the idea of local district councils was dropped and in its place Community Health Councils for each constituent district were recommended. These Community Health Councils would not be directly representative of local interests, as this would lead to a "dangerous confusion between management .... and the community's reaction to management". The new Area Health Authorities would therefore be required to set up Community Health Councils in each district and to appoint the council members "after consultation with a wide range of interested local organisations"[2].

The future of the family practitioner service was to remain unchanged, and would be managed in future together with dentists, pharmacists and opticians by an area committee similar in composition to the executive councils[3]. As far as the teaching hospitals were concerned, the teaching districts,

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[1] Ibid., para. 16, p. 9.

[2] Ibid., para. 20, p. 10.

[3] Ibid., paras. 21 and 22, pp. 10 - 11.

those where there were substantial facilities for medical and dental clinical teaching, were to be administered as part of the areas in which they were situated, and special arrangements were to be made to ensure the best possible relationship between the university and the administrative bodies[1].

These changes from the second Green Paper made in the Consultative Document were proposed for reasons of "managerial efficiency", and the regional and area authorities were referred to collectively as "managing bodies". As the Consultative Document put it, "Direct supervision of some 80 to 90 area authorities by the central department, as proposed by the previous government, would not make managerial sense"[2].

Two exceptions were made to the managerial model, both for discernible political reasons. First, local authorities were permitted to appoint members of area health authorities, to a number as yet undetermined, in order to provide for the need for co-ordination, which at this point was given priority over the need for managerial efficiency[3]. Second, the teaching hospitals were given special district committees with a chairman and some members appointed by the Secretary of State[4]. Clearly, this would mark them off from the orthodox hierarchy, and enable them to appeal to the

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[1] Ibid., para. 23, p. 11.

[2] Ibid., para. 6, p. 6.

[3] Ibid., para. 17, p. 9.

[4] Ibid., paras. 17 and 23, p. 9 and p. 11.

Secretary of State over the heads of area and regional authorities, and would clearly enable legislation to gain an easier passage in the House of Lords, where the teaching hospitals and universities would be represented in some strength.

The Consultative Document arguably had important implications in relation to the politics of the medical profession. There would clearly be some tendency for general practitioners to concentrate their attention on their special local committee at area level. Equally, the consultants would be able to continue to exert their influence at regional level where vital decisions concerning the hospital service would be taken such as the location of particular specialties and the provision of manpower and buildings. The result might be, as Abel-Smith put it, that

> "Sir Keith's decision to lock appointed representatives of the health professions out of his managerial structure is likely to make the professions a powerful force resisting change"[1].

Reaction to the Consultative Document included a great deal of criticism about the emphasis placed on 'management' and the failure to provide for greater public participation. As The Times put it "The main weakness of the Consultative Document is that it pays too little attention to satisfying and reassuring the public. Efficiency is not the sole criterion ...."[2]. The Institute of Health Administrators on the other hand, welcomed the emphasis on management but also referred to the problems of co-ordination that would

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[1] B. Abel-Smith, "The Politics of Health", New Society, 29 July, 1971, p. 191.

[2] The Times, 18th May, 1971.

arise between the health and local authorities[1].

Other criticisms concerned the balance of power between the hospitals and general practice, and between the consultant and the doctor. New Society said that the scheme meant that the consultant would continue to exert influence at regional level thus annihilating Sir Keith's plans for a unified health service. "The regions are likely to become much more consultant-oriented .... The General Practitioners .... will concentrate on their own special committee at area level, while the critical planning decisions are taken at regional level ...."[2]. The Lancet also felt that the continuing separation of the family practitioner services from the other branches of the NHS would mean no further unification[3], and this point was also made by the Society of Medical Officers of Health[4]. Nevertheless, the General Practitioners themselves did not seem too concerned about the split between the interests of the consultants and the General Practitioners, according to the responses of a sample of General Practitioners to a questionnaire survey undertaken by the "General Practitioner"[5].

Criticism was also levelled at the proposed Community Health Councils for their lack of direct local representation. As the Lancet put it, "Unless the members of the Community

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1 The Hospital, September, 1971, pp. 326 - 7.

2 B. Abel-Smith, "The Politics of Health", New Society, 29 July, 1971, p. 190.

3 The Lancet, "The Consultative Document" 4 September, 1971, pp. 538 - 9.

4 Public Health, November, 1971, pp. 43 - 8.

5 The General Practitioner, 8 October, 1971, pp. 14 - 15.

Health Councils are appointed independently of the management structure.... the public will be justified in considering that its opinion is neither wanted, nor obtained". It suggested that a national agency should replace the Area Health Authorities in appointing members of the Cummunity Health Councils[1]. The British Medical Journal made the same point: "The Community Health Councils as proposed in the document, though decorated with worthy intentions, seems unlikely to attract to their membership local citizens of the calibre that is needed"[2].

In August, 1972, the White Paper[3] was published after over 600 organisations and individuals had commented on the Consultative Document. In the interim, two studies had been started, one by McKinsey and Co. Inc. and the Health Services Organisation Research Unit of Brunel University into the detailed management arrangements at regional, area and district level[4], and the second by the Working Party on Collaboration between the NHS and Local Government[5].

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1 The Lancet, "Management and Participation," 6 May, 1972, pp. 1006 - 7.

2 British Medical Journal, 5 August, 1972, p. 310.

3 National Health Service Re-organisation: England. Cmnd. 5055, 1972.

4 Published as Management Arrangements for the Re-organised National Health Service, HMSO, 1972.

5 Published by the DHSS as (i) A report from the Working Party on Collaboration between the NHS and Local Government on its activities to the end of 1972, HMSO, 1973. (ii) A report from the Working Party on Collaboration between the NHS and Local Government on its activities from January to July, 1973, HMSO, 1973. (iii) A report from the Working Party on Collaboration between the NHS and Local Government on its activities from July, 1973 to April, 1974, HMSO, 1974.

The major change which was made was that the Area Health Authorities were now to get four members specifically nominated by the co-terminous local authority[1]. It was also indicated that members would be appointed for their "personal qualities" as distinct from their "management ability", a diplomatic touch[2]. The White Paper also made explicit the integration of the teaching hospitals within the health service, and envisaged the introduction of a modern budgeting and accounting system, together with the right of the health authorities to carry over unspent balances from each financial year[3], features which were all welcomed by The Economist[4]. The Lancet felt able to comment

> "the proposals (in the White Paper) are in some ways an improvement on the Consultative Document, and the professional's voice has obviously been heeded in its drafting"[5].

Criticism continued to be levelled however, at the position of the general practitioner. The Guardian complained that the doctors "have once again proved too powerful for any meaningful integration .... Any chance of closer monitoring of the doctors seems as remote as ever"[6]. The New Statesman

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[1] Para. 98, p. 24.

[2] Para. 96, p. 24.

[3] Paras. 113 - 126, pp. 29 - 31 and paras. 158 and 159, p. 39.

[4] The Economist, "Fourth Time Final?", 5 August, 1972, p. 19.

[5] The Lancet, "Management and Participation" 6 May, 1972, pp. 1006 - 7.

[6] The Guardian, "New Model Health Service" 2 August, 1972, p. 12.

pointed out that the Family Practitioner Committees were "nothing but the old local executive committees under a different name"[1] The Economist[2] and the Sunday Times[3] expressed the same concern, and the Lancet made the identical point: "Pandering in this way to the desire of general practitioners to emphasise the independence of their contracts may well mean that the health services .... will be tripartite in 1974 .... Nor is unification made any more real by the fact that no firm suggestions have been made for the future of the school health service ....", and anticipated that the doctor "at present emerging from the age of 'cottage industry', may be forced back into isolation"[4].

> However, from the doctor's point of view, the General Practitioner said:
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> " .... GPs themselves may not be confident of the future of their status as independent contractors .... the FPC's job will be restricted to dealing with contracts, terms of service and complaints. Many of the representative powers of the Executive Councils will be lost. FPCs, for example, will have little to do with the building of health centres .... GPs will have to fight hard to retain their autonomy"[5].

The Hospital and Health Services Review dealt fully and critically with the excessive emphasis on management, the non-integration of the contractual services, the lack of democratic representation and the general ambiguity of the White Paper. However, it concluded :

> "What the debate since the 1968 Green Paper has done is, first, to make some form of integration

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1 New Statesman, "Preserving Cottage Medicine, 4 August, 1972, p. 154.

2 The Economist, "Fourth Time Final?", 5 August, 1972, p. 19.

3 The Sunday Times, "Doctors Win Again" 6 August, 1972, p. 14.

4 The Lancet, "The Consultative Document" 4 September, 1971, pp. 538 - 9.

5 The General Practitioner, 4 August, 1972.

> inevitable, second, to explore the various possibilities and, third, to make people anxious for certainty and actual change, rather than more debate and uncertainty. No concensus on all important matters has been reached or seems possible. Allowing for the constraint within which he has had to work, Sir Keith has produced an acceptable scheme, despite its weaknesses"[1].

The rationale behind the Conservative approach to re-organisation was as follows. Labour had made proposals for re-organisation and local government reform with unitary local authorities and area health authorities matching these. However, the Conservatives thought the unitary proposals too remote from the citizen, and therefore brought in districts. It was thought impossible to re-organise the NHS within local government because nothing short of national taxation could bear the cost of the NHS, and because it was opposed by the medical profession. There is no doubt that unification of the NHS within the local government structure is what both main political parties would have preferred[2]. As Sir Keith Joseph put it in the House of Commons debate on the NHS Re-organisation Bill :

> "No doubt in a perfect world .... the answer would be to unify the health services within local government. That would provide what many of us would like to see in a perfect world, namely, one decision-making authority in every area, with one budget. But we do not live in a perfect world, and that is not practicable. The Labour Government did not believe, nor do this Government, that it is practicable to unify the health services within local government"[3].

The NHS in future would have to absorb local authority health services, as the social services had been unified under local

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[1] Hospital and Health Services Review, September, 1972.

[2] Information provided by Lord Aberdare in an interview.

[3] 853 H.C. Deb. 5s., col. 926.

authorities, and therefore local government reform and NHS re-organisation had to take place on the same day. For this purpose, Lord Aberdare wanted legislation on the NHS to go through in 1972, but the legislative programme was too crowded and local government reform got into the 1972 programme, and NHS re-organisation did not, which gave insufficient time for its implementation[1].

There was also the problem of the dividing line between local social services and NHS services where there was a vital need for co-operation in community care, and it was felt that this line should be as indistinct as possible. The duty was therefore laid on both authorities to co-operate, and Joint Consultative Committees were set up. This also involved a major decision that area health authorities would have the same boundaries as counties, as this was necessary for the purpose of collaboration, although it was not necessary for NHS purposes alone. However, this raised the question as to whether the Regional Health Authorities were necessary. The political decision was firmly taken to maintain the Regions for reasons of good management and administration[2]. The DHSS could not deal effectively with 90 area health authorities, and it felt that its dealings with Regional Hospital Boards in the past had been good. Regions were needed for strategic long-term planning and the hospital building programme, and some services, e.g. neuro-surgery, needed regional organisation to sort out problems of overlap and priorities between area health authorities. During the course of the Management Study, attempts were made

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[1] Lord Aberdare, "The Conservative Case", lecture given at the London School of Hygiene and Tropical Medicine, 8 April, 1974.

[2] Information provided anonymously by a member of the Health Services Organisation Research Unit, Brunel University.

to question the necessity for a regional tier, but these were defeated by the refusal of the civil servants involved on the Steering Committee to reconsider the question on the grounds that the decision to have a regional tier was a political decision which had already been taken. No doubt the desire of the civil servants for a buffer between the DHSS and the field organisations was a factor here, as was the desire of the consultants to be contracted at regional rather than area level in order to keep themselves removed from the tier with local government connections. Districts, on the other hand, were not established as a third tier, because this would create a managerial monster and therefore districts were to be an integral part of area administration, and were left as part of the management arrangements entrusted to the Steering Committee and McKinsey, who concerned themselves with basing these arrangements on good management principles rather than with policy decisions. Public participation was provided for through the proposed Community Health Councils.

During the course of the passage of the Bill through Parliament, the Government showed itself willing to adjust matters concerning the professional advisory machinery within the NHS, staff consultation, and the independence of community health councils, but beyond these, few concessions were made. This reflected Sir Keith's unwillingness to weaken the ability of the centre to determine priorities in resource allocation. This meant that members of the health authorities were to be appointed, not elected, and that only

4 out of 15 members of the area health authorities were to be appointed by the corresponding local authority, with no provision for representatives of the local authority professional staff. This no doubt reflects the Treasury view that ministerial appointments were necessary to secure full financial control. This may have enabled Sir Keith to get the extra funds for the chronic sector, noted above, and to obtain other concessions, notably the limited freedom given to health authorities to use funds allocated for capital expenditure to meet revenue expenditure and vice versa, and arrangements to enable unspent revenue allocations to be carried over from one year to the next. It may also be that Sir Keith wanted to prevent the health professions from controlling resource allocation, as it was the policy of the DHSS to divert resources to less prestigious specialties such as geriatrics and mental illness, and therefore the pressure of the more prestigious specialties to obtain control of resource allocation for the medical profession had to be resisted. This is quite consistent with granting greater participation in management to the medical profession, e.g. at district level, where the use of resources is involved, once the resources have actually been allocated.

All these factors may explain the pattern of Conservative thinking in Government about the NHS re-organisation.

CHAPTER V

The Treasury

Commenting upon a motion in the Committee considering National Health Service (Money), Mr. Richard Law[1] said :

> "The most remarkable thing about this Financial Resolution is that it covers a tremendously wide field, involving large sums of money, for a variety of purposes, and only once is any specific sum mentioned - that of £66 million"[2].

This comment reflects the absence of Parliamentary debate on the financial aspects of the National Health Service Bill, in spite of considerable apprehensions which had already been aroused. The Beveridge Report[3] had estimated that the cost of a comprehensive health service for Great Britain would be £170 million per annum, and optimistically predicted that its development and consequent reduction in need would cancel out, thus leaving cost unchanged by 1965. The Coalition Government's White Paper of 1944[4], estimated the cost at £132 million, but did foresee that the cost for 1948-9 would be "considerably increased" owing to some expansion of services, "higher prices and wages, and payment for specialist services in the voluntary hospitals"[5].

It was not long before the increasing costs of the National Health Service caused mounting concern. In February, 1949, a Supplementary Estimate of £52.8 million produced a heated debate in the Committee of Supply. Thus,

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1 Conservate M.P. for Kensington South.

2 422 H.C. Deb. 5s., col. 418.

3 Report of the Committee on Social Insurance and Allied Services (Beveridge, Ch.) Cmnd 6404, 1942. See Appendix A, p. 201.

4 Ministry of Health, A National Health Service, Cmnd 6502, 1944.

5 Ibid., Appendix E., p. 84.

Mr. R. Assheton[1] said :

> "Finally, I want to refer to the fact that the Health Service is costing very nearly three times what we were told when the National Health Service Bill was introduced on 19th March, 1946. In front of it is a Financial Memorandum, and the final figure of that Memorandum is: 'The net annual expenditure falling upon the Exchequer is £95 million'. The original estimate, introduced by the Minister of Health last spring for England and Wales, was £132 million. He has now come along with an additional Supplementary Estimate for £52 million .... let us not forget that these figures for the Estimate and for the Supplementary Estimate cover only nine months of the year whereas next year we shall have to foot the bill for 12 months; and that the Estimate and Supplementary Estimate before us, without any provision for anything else, mean a total overall figure for both kingdoms of something like £277 million"[2].

The Estimate for 1949-50 was £228 million, and was followed by a Supplementary Estimate of £98 million. Captain H.F.C. Crookshank[3] deplored "the failure of the Chancellor of the Exchequer to enforce his own instructions to Departments not to overspend so extensively their Estimates"[4]. Sir Stafford Cripps replied, "I believe it is necessary to call a halt to further developments of these services. We must, therefore, regard the Estimates for the forthcoming year as a ceiling beyond which we must not be carried"[5]. A ceiling of £400 million was therefore placed upon expenditure, and charges for dentures and spectacles introduced in May, 1951. These policies were continued by

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[1] Conservative M.P. for the City of London.

[2] 461 H.C. Deb. 5s., col. 1368.

[3] Conservative M.P. for Gainsborough, and Minister of Health, 1951-2.

[4] 472 H.C. Deb. 5s., col. 916.

[5] Ibid., c. 937.

the Conservative Government later in the year. "We shall keep the cost of this Service .... within a ceiling of £400 million" the new Chancellor of the Exchequer, Mr. R.A. Butler said in January, 1952[1], but the Danckwerts award[2] demolished the ceiling, and in 1952-3 expenditure rose to £420 million. As Mr. Iain Macleod put it:

> "We have been committed to a ceiling of £8 per head. There has been no examination .... to decide whether it should be £7, £8, £10, £11; we do not know. I suggest that .... we should study the proportion which health ought to bear to the whole of our national expenditure"3.

The continuing unease about the cost of the Health Service resulted in the appointment of the Guillebaud Committee[4] in April, 1953, with terms of reference "to advise how, in view of the burdens on the Exchequer, a rising charge upon it can be avoided, while providing for the maintenance of an adequate service". The Committee reported in 1956 that "the National Health Service has absorbed a decreasing proportion of the country's resources since the first full year of the Service" and it "found no opportunity for making recommendations which would .... reduce in a substantial degree the annual cost of the Service"[5]. These findings were borne out by the work of Abel-Smith and Titmuss[6]. They found

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1 495 H.C. Deb. 5s., col. 54.

2 Published 24th March, 1952.

3 498 H.C. Deb. 5s., col. 962.

4 Report of the Committee of Enquiry into the Cost of the National Health Service (Guillebaud, Ch.), Cmnd. 9663, 1956.

5 Ibid., p. 239.

6 B. Abel-Smith and R.M. Titmuss, "The Cost of the National Health Service in England and Wales", University Press, Cambridge, 1956, pp. 58, 60, 63 and 165.

that whilst the gross current cost of the National Health Service had risen from £333.2 million in 1948-9 to £453.4 million in 1953-4, net cost as a percentage of gross national product had declined from 3.51% to 3.24%. They also indicated the significance of a general rise in prices, and the lack of foundation of the widely-expressed fears of the effect on costs of an ageing population. Nevertheless, as Seale pointed out :

> "the country, even now, has still not recovered from the shock of the large supplementary estimates of the first two years of the Service, and the considerable miscalculations of the health service planners"[1].

By 1969-70 the total cost of the Health and Welfare Services in England and Wales was £1,754 million[2]. The increasing cost of morbidity which caused such concern to the Treasury may be illustrated as follows.

Table 1. Expenditure on the NHS[3]

This table shows the gross cost of the NHS in Britain and the cost as a proportion of national income. It includes current and capital expenditure by central and local government and payments by NHS patients. It also shows the cost of the NHS in terms of the 1949 level of the £.

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[1] J. Seale, "Assumptions of Health Service Finance" in The Lancet, 25 June, 1960, pp. 1309 - 1403.

[2] DHSS Information Division, Intelligence Section.

[3] Office of Health Economics, Information Sheet No. 21, March, 1973, Central Statistical Office.
See also Miles C. Hardie, "What Should We Spend on Health Care?", KFC Reprint No. 846, February, 1974.

Year	NHS as Percentage of National Income*		Gross Cost of NHS £ (million)		Purchasing Power of £ (1949=100)	Cost of NHS at 1949 level of £ (£ million)
1950	4.42		477		97.3	464
1951	4.22		500		89.2	446
1952	4.09		523		84.1	440
1953	3.98		548		82.7	453
1954	3.89		567		81.3	461
1955	3.91		607		78.6	477
1956	3.93		662		75.3	498
1957	4.04		721		73.0	526
1958	4.11		764		71.0	542
1959	4.24		828		70.5	584
1960	4.33		902		69.9	631
1961	4.40		981		67.9	666
1962	4.41		1025		65.4	670
1963	4.42		1092		64.2	701
1964	4.46		1186		62.1	737
1965	4.62		1308		59.4	775
1966	4.85		1434		57.3	822
1967	5.12		1594		55.9	891
1968	5.23		1741		53.5	931
1969/	5.33	5.15	1886	1823	50.8	926
1970		5.38		2083	47.6	992
1971		5.38		2369	43.5	1031

* National income is equivalent to Gross National Product less capital consumption.

/ Change in definition of NHS from 1969: certain local authority services transferred from NHS to Social Services

There was, therefore, a continuous struggle against an ever-rising level of expenditure, and rationalising services became less important than limiting the budget, and this was reflected in the Treasury's attitude in the early

1950s.

> "Treasury control on Health Service spending tightened: all changes in expenditure and hospital staffing were subjected to detailed scutiny. But the effect of these measures was only to divert the attention of administrators at all levels of the Health Service from the basic problems of improving the long-run use of health-care resources to the immediate details of holding down costs. Spending, nevertheless, continued to rise and after 1951-2 was never again below the official 'ceiling'"[1].

Feldstein emphasised that:

> "in the years immediately after 1948 the Treasury did exercise detailed control over individual Ministry decisions. Although this may have helped to contain total NHS spending, it contributed little to rationalising the use of Health Service resources. It did, however, engender resentment against 'unnecessary Treasury interference' and promoted the feeling that the Health Service would be more efficiently run if the NHSwere transferred from its departmental framework to public corporation status"

However, Government circles felt the departmental organisation had to be retained, and the Guillebaud Report also refuted this argument[2].

In 1957-8 one of the sub-committees of the Select Committee on Estimates expressed criticism of the way Treasury control was exercised, describing it as "a complex of administrative practice that had grown up over the centuries", rather than a "system". The sub-committee doubted the efficacy of these practices in modern conditions, and felt that the Treasury was in danger of falling between the two stools of "candle-ends" economy left over from the past, and the new theory of departmental responsibility and

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[1] Martin S. Feldstein, "Developments in Health Service Administration and Financial Control", in Medical Care, July/September, 1963, p. 171.

[2] Ibid., p. 174.

partnership which might not have been wholeheartedly accepted[1].

As a result, the Plowden Committee was set up to examine the control of public expenditure and made its report in 1961[2]. The Report made three main recommendations. First, it was suggested that expenditure should be surveyed as a whole over a period of years in relation to prospective resources. This type of work had already been carried out by the Treasury and certain departments, notably in the "forward looks" on Defence covering the succeeding four or five years, and in the regular long-term forecasts on public investment. This work, it was felt, should be carried further over the whole field of public expenditure, where surveys covering a period of years should be made regularly. There should also be regular surveys of the possible resources available to meet this public expenditure, and these surveys should be available to Ministers when making decisions on particular cases calling for considerable expenditure during these years. As the Committee pointed out, commitment to these regular surveys would require new methods of control and new techniques of administration in the Treasury and other departments - hence their recommendation that the organisation of the Treasury should be received. In making this recommendation, the Committee pointed to the increasing pressure at both central and local levels for innovation and improvement requiring increases in public expenditure, a point particularly relevant to the circumstances of the National

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[1] Lord Bridges, The Treasury, Allen and Unwin, London, 1964, p. 137.

[2] Report of the Committee on the Control of Public Expenditure, (Plowden, Ch.), Cmnd. 1432, 1961.

Health Service. It declared that :

> "decisions involving substantial future expenditure should be taken in the light of long-term surveys which would relate expenditure to resources. Above all, a system must be devised to counter the tendency for decisions to be taken piecemeal"[1].

The second main recommendation of the Plowden Committee was that greater attention should be paid to the systematic improvement of management throughout the public service. This recommendation had four aspects. First, the Committee endorsed the existing arrangements whereby the Permanent Secretary is responsible not only for advising the Minister on major issues of policy, but for carrying out approved policies and for the administration of the Department. The Committee said, "In our judgement, indeed, it is becoming increasingly necessary for the Permanent Secretary to devote a considerable amount of personal time and attention to problems of management"[2]. The second aspect was the supreme importance of the Treasury's management duties in personnel matters, and third, the Committee suggested that the Treasury should accept responsibility for the development of management services in Whitehall

> "...as for example the quantitative techniques of statistics, costing, accountancy, operational research and so on, as well as organisation and methods and training; for taking the initiative in the introduction of new techniques; and for keeping an oversight over the practice of all the Departments, both to encourage and to help them in the improvement of efficiency and economy in management, and to ensure that Whitehall gets the full benefit of cross-fertilization of ideas introduced by individual Departments"[3].

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[1] Lord Bridges, The Treasury, Op. Cit., p. 139.

[2] Paragraph 47.

[3] Paragraph 50.

Lastly, the Committee recognised the necessity for changes in existing techniques of administration, and the introduction of new techniques. The Committee said:

> "We are conscious of the fact that the developments of public administration which we envisage throughout our Report would impose a heavy additional load of responsibility upon the Treasury in its work as the central Department exercising control over public expenditure and responsible for the overall management of the Civil Service. If these developments take place, there will, over a period of time, be considerable changes in the nature and pattern of the Treasury's work. Some of the present work of the Supply and of the Establishment Divisions may well cease to be necessary; a great deal of new and testing work, perhaps in some cases requiring different qualities and experience, will take its place. We have not attempted in this Report to follow the implications of these changes. Much will depend upon the ability of the Treasury to adapt itself to a new array of central responsibilities and a different kind of relationship with the departments: it will be necessary for the Treasury to review its organisation to meet these demands on it"[1].

It is interesting to note that in 1960, Mr. Enoch Powell also made some observations on Treasury control over finance shortly after he had resigned from the Treasury because of the increase in the draft estimates, and shortly before he became Minister of Health[2].

> " .... In an age of inflation, the Treasury cycle needs to be supplemented by continous - horrible, but necessary word! - 'progressing'. The Treasury and the finance divisions of the spending departments need to be constantly reporting any change, as soon as it comes in prospect, which would put up money costs, and asking in good time for the decisions of administration or policy by which the effect of the change, if it occurs, can be counteracted. To wait until November before seeing what has happened and taking a view on the consequences is scarcely more rational in today's circumstances than to look at the reserves and exchange rates once a year".

He then turned to what he called three classes of automatically

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[1] Paragraph 59.

[2] J.E. Powell, "Treasury Control in the Age of Inflation", in The Banker, April, 1958, pp. 216-9.

expanding service.

> "One is where the number of persons for whom provision is made- such as children at school, or retirement pensioners, or council house tenants - is subject to a natural increase; or else where the service prescribed by statute is so comprehensive that at any time the actual provision can be claimed to fall short of the minister's statutory obligations - the National Health Service is the classic instance .... these built-in escalators have not only the direct effect of taking large areas of public expenditure out of Treasury control. There very existence has a demoralizing effect over the whole field. It is hard both for the Treasury and for spending departments to exercise the full rigour of control where the machinery is intact and effective, if both parties know that infinitely larger sums than any which their utmost efforts could achieve by economy and retrenchment are being expended in other sectors without any possibility of refusal or supervision"[1].

From this, he came to the following conclusion,

> "We are forced to recognise again that estimating can no longer be an annual operation. It must not only be a continuous process through the financial year; it must also look forward over a series of years at once and determine the end-point at which it is intended to arrive, not merely after twelve months, but after two, three or even four years. For the escalator elements in public expenditure can be controlled only by deciding in advance how they are to be accommodated or, alternatively how the escalator is to be stopped. Thus, the strictly annual framework whichhistorically enabled the House of Commons to get control over the Government is now obsolete. To enable the Government to get control over public expenditure it must give place to a system capable of taking both a more intensive and a more extensive view.
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> There have been the beginnings of a more extensive approach in the forward estimates of 'public investment' now being attempted for two or three years ahead. Such an estimate, for example, was implicit in the Chancellor's declaration of September 19, 1957, that the total value of this investment in 1959-60 as well as 1958-59 would not be allowed to exceed £1,500 millions. It is significant that the innovation was made in a field lying mainly outside that of the annual estimates"[2].

Mr. Powell concluded by pointing out:

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[1] Ibid., p. 218.

[2] Ibid., pp. 218-9.

"The requirements of a more intensive and extensive Treasury control has far-reaching implications for the habits of government itself. A budget is, or ought to be, an expression - perhaps the most delicate and comprehensive expression - of the general policy and aims of a Government. Estimating and budgeting in terms of years rather than months is only possible if assumptions on major points of policy are made .... strictly annual estimates and a strictly annual budget are of no use for making and executing policy"[1].

As Minister of Health, Mr. Powell returned to a similar theme in his Lloyd Roberts Lecture[2]. Taking up arguments recently put forward by Dr. John Seale[3], Mr. Powell refuted the notion that there was a proportion of the national income which the Government should regularly provide for the National Health Service. Rather, he felt that the amount of expenditure was and must be, arbitrary.

"There never was a moment when anyone in Britain sat down, or could sit down, and determine in advance the quantum of public expenditure on health services". The bill in 1950-51, for instance, "was what got itself spent by the pre-existing services that had been taken over", and the bill ten years later was its direct lineal descendant - the one being derived from the other by a process of additions and substractions.

"The true picture is thus of a mass of different expenditures which grow, or are allowed to grow, subject to a compression exercised, not always very precisely or consciously, by other demands upon public expenditure and upon the national income .... After the event, the resultant expenditures may be expressed as percentages of the gross national product for the relevant year. Indeed, it is possible to express future intended limits on expenditure as percentages of forecast future gross national product. But, in practice the amount and the limitation are not derived from these calculations: they are determined by much

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[1] Ibid., p. 219.

[2] Reported in The Lancet, 28 October, 1961, pp. 968-70.

[3] See The Lancet, 28 October, 1961, and "The Health Service In An Affluent Society" in British Medical Journal, volume ii, 1 September, 1962, pp. 598-602.

> more complex, less conscious, and in part actually unascertainable forces and pressures, which produce from year to year a certain alteration in the size and pattern of the component parts and of the whole" .... "not even a conscious arbitrary decision: only a bundle of public expenditures moulded from year to year by a variety of limitations partly conscious, partly automatic".

He went on to point out the Government's intention that over the next four years, expenditure on the publicly financed health services would rise in total by not more than about 2½% per annum; but this 2½% did not represent in any way the advance which these services "can, should, or will" make in these four years.

In office, Mr. Powell was able to give substance to his thoughts in the Hospital Plan for England and Wales of 1962[1]. In concluding the debate on this plan, Mr. Powell said,

> "It is, in fact, an illustration of the creative use of the long-term forecasting of expenditure. I think it is right that we should recognise the importance of the decision taken by my hon. and learned friend the Chancellor of the Exchequer, a decision which is matched in many other fields of Government policy and expenditure, to lay down a long-term forecast of expenditure within which planning could proceed. .... We shall be sure from now onwards that the great sums of money which are applied to new hospital developments are expended within the framework of the Health Service as a whole"[2].

The need for co-ordination within the tripartite structure was also recognised by Mr. Powell, in establishing a comparable base for the Health and Welfare Services.

> "On the day - and this was no accident - on which this plan was published, I asked all the local health and welfare authorities to prepare their own ten-year plans for the development of their own health and welfare services for community care".

He went on to say:

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[1] Ministry of Health, A Hospital Plan for England and Wales, Cmnd. 1604, 1962.

[2] 661 H.C. Deb., 5s., Cols. 751-2.

"It may have been noticed that no less than one quarter of the text of this plan is devoted to community care, to care outside the hospital. That is right, because the provision which is made inside the hospital is complementary to that made outside"[1].

In 1962, the Treasury carried out re-organisation based on the recommendations of the Plowden Report. As a result of these changes, the Treasury became organised on a more functional basis, with a Second Secretary responsible for the Public Sector Group comprising two blocs of divisions, namely Defence and Science, and the Public Sector. The Ministry of Health and the National Health Service was included under the Social Services division under the Civil Public Sector, with an Assistant Secretary and an Under Secretary. Under the Management Group was included a Management Services (General) set up as part of the 1962 re-organisation, in accordance with the Plowden recommendation that the Treasury should accept responsibility for the development of management services in Whitehall. It was expected to carry out comparative studies of management techniques, and to develop the concept of cost consciousness within the Civil Service. It was also to concern itself with the distribution of functions between departments and some aspects of the machinery of government. Thus, after 1962, there existed in Central Government, at least in more explicit form, a mechanism for dealing with costs and resource planning, and for associating these with management structure.

After 1962, therefore, the Ministry of Health and the

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[1] Ibid., col. 157.

Treasury were able to lengthen their horizons and to free themselves from the burdens of detailed supervision of decisions better left to local operating units, even though the formal process of budgeting remained much the same. The actual budgeting operation changed substantially within the formal appropriations, and Departmental responsibility increased and detailed Treasury supervision waned. The agreement referred to above[1] that NHS expenditure would increase annually at 2½% permitted lengthening the budgeting period from one to three years. As far as capital expenditure was concerned, advance specification of cost, and the establishment of quality norms acceptable to the Ministry and the Treasury, replaced detailed vetting of each proposed project, whilst the Hospital Plan provided a fifteen-year programme for construction and remodelling activities on the basis of uniform bed-population ratios in each area.

The introduction of the forward-look budget was also significant in that by providing both detailed estimates for the coming year, and an outline of the sums to be spent in the subsequent two or three years, it removed the pressure for rapid vetting of annual requests and made way for more deliberate long-range planning. As the size of their budgets was known in advance, departments could now plan major structural changes in their spending patterns, and decisions were necessary at Cabinet level concerning each department's budget for the three or four-year planning period. Thus, in early 1962, the Regional Hospital Boards submitted their

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[1] See p. 139.

estimates for the fiscal year 1962-3 and forward-look budgets for 1963-4 and 1964-5, whilst the Ministry conducted similar forward-looks for the executive council and centrally administered services.

Initially, forward-look budgeting failed to realise its full potential in the NHS, as most Regional Hospital Boards continued to concentrate their attention on the estimates for the coming year, and regarded the amounts in the forward-look exercise as capable of more serious revision in the future. More important, the RHBs failed to see the purpose of the exercise as providing them with an opportunity for planning the future shape of their services, and regarded the forward-look budgeting exercise as predicting future expenditures by projecting current trends or calculating the operating costs of capital projects being started in the present year. Thus, the RHBs tended to limit their attention to future development and to the use they would make of the agreed annual increases, assuming that the basic sum would be spent as previously without considering how their entire appropriation might be reallocated during the planning period among the different services and inputs.

Forward-look budgeting also had implications for the use of management studies and operational research, as it became desirable that normative studies should seek the optimal allocation of resources among competing claims rather than search for 'necessary' or 'adequate' standards of care. It also had implications for the tripartite structure of the NHS, where there was no single source of planning and direction, and co-ordinated decision-making was extremely

difficult, particularly having regard to the lack of co-terminous districts between the three branches. This meant that a fully unified attack on the problems of community care for the aged, the chronic sick, and the mental patient etc.

As Feldstein put it,

> "The complete separation of finance among the branches accentuates the administrative difficulties of co-operation. The general practitioner receives no extra compensation for providing home care and may thus favour longer stay in hospital. Efficient co-ordination of institutional and domiciliary care requires not only better day to day collaboration and the lowering of financial barriers to intra-service co-operation, but long-range planning of the allocation of resources and responsibilities among the three branches"[1].

One example of this kind of planning was the policy of the Ministry to decrease the number of hospital beds and to increase the proportion of funds spent by local authorities. Thus, whilst public expenditure on health care was to increase by 2½% per annum, hospital expenditure was limited to 2% increases, so that local authority expenditure could increase more rapidly. However, facilitating changes in the allocation of total spending among the branches is only one facet of the problem of co-ordinated planning, as it was necessary that the three branches to be developed to provide services that would complement each other as part of an integrated programme. This was impeded by the tripartite structure, as was indicated by the production of separate plans for hospitals, local authorities and general practitioners, with no unified plan for the NHS as a whole.

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[1] Martin S. Feldstein, "Developments in Health Service Administration and Financial Control", in Medical Care, July/September, 1963, p. 175.

It is against this background that the establishment of the Health Programme Committee must be seen as part of the new partnership in forward-look budgeting between Ministry and Treasury. The Committee was set up in 1966, and consisted of representatives of the Ministry of Health, Scottish Home and Health Department and the Treasury, and examined facts and trends in the hospital service. This Committee did not specifically consider re-organisation of the NHS, as it was more concerned with the extent of capital absolescence in the hospital service and the problems of measuring the results achieved from a given investment. However, the need for close co-ordination between hospital boards and local authorities on the development of services, for example for the elderly, was pointed out, and it was noted that the Ministry of Health was undertaking a review of the effectiveness of this co-operation, and that this organisational problem was part of the major question of the tripartite structure of the NHS and of its relation to the local authority Welfare Services, which again was being studied by the Ministry at that time (June, 1967). At a high level meeting between the Treasury, Department of Economic Affairs, Ministry of Health and the Scottish Home and Health Department, held in October, 1967, on the report of the Health Programme Committee on trends in the hospital service it was also noted that although a great deal had been done to unify the administration of the NHS consistent with its existing regional structure, there was still a long way to go.

Apart from the Health Programme Committee, another aspect of the Treasury's concern to establish a more effective

approach to the problems of management in the National Health Service arguably lies in its attempts to 'colonise' the Ministry of Health and the DHSS. Kogan has drawn attention to the tendency for the post of Permanent Secretary in the Social Service Departments to be filled by candidates with substantial Treasury or related experience[1]. In the case of Health, the Permanent Secretary from 1964 until 1968 was Sir Arnold France who had spent twenty years in the Treasury. He, in fact, was largely responsible for drafting the first Green Paper with its heavy emphasis on management. He was succeeded by Sir Clifford Jarrett who came from the Admiralty and Pensions and National Insurance. In 1970, the Treasury influence re-asserted itself with the appointment as Permanent Secretary of Sir Philip Rogers who came via the Treasury and the Civil Service Department. When the appointment of Mr. T.E. Nodder[2] to the key post of Under-Secretary in charge of the newly-established long-term planning unit in 1967 is also taken into account, it can be seen that the possibility of imported influence from the Treasury in connection with the National Health Service re-organisation is significant.

During the same month, October, 1967, the Treasury received the first explicit indication of the Ministry of Health's intention concerning the re-organisation of the NHS, in the shape of a draft paper which the Minister proposed to lay before the Social Services Committee of the Cabinet,

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[1] M. Kogan, The Government of the Social Services, Sixteenth Charles Russell Memorial Lecture, 1972.
M. Kogan, Social Services: Their Whitehall Status, New Society, 21 August, 1969.

[2] Mr. T.E. Nodder came as a Principal from the Treasury to be Mr. Kenneth Robinson's Private Secretary.

seeking the approval of the Committee for setting in motion an urgent internal examination of the possibility of strengthening and improving the administrative structure of the medical and related services. It was also proposed to inform the Royal Commission on Local Government, the Seebohm Committee, and the Royal Commission on Medical Education, and to make a statement announcing the intention in the House of commons.

The Treasury was in no doubt that the review, and a public commitment to it, should be supported. The lack of effective co-ordination, management and control, and the notion that it did not offer value for money made such a review desirable in the Treasury's eyes, though it did not itself originate the suggestion[1].

By the end of November, 1967, an outline of what the Ministry wished to put in their Green Paper was available to The Treasury. It suggested some 40 Area Boards which would parallel the local authority structure which was believed likely to emerge from the report of the Royal Commission. It was envisaged that these Area Boards would be 100% Exchequer financed, and that there would be provision for a "democratic element" on the Boards. Beyond this, the proposals were vague about such matters as the relationship between the health departments and the proposed Area Boards, and on the question of the accountability and responsibility which would fall at each level. In February, therefore, the Treasury sought clarification of the Ministry's views at a meeting from which it emerged that the Ministry thought that full political and financial responsibility would be retained by

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[1] Much of the information for this section, particularly for pp. 146-156, was derived from material from a case study prepared for the Civil Service College, 1969-70.

the Ministry, and that the Area Boards would be the Minister's agents in the same way as the Regional Hospital Boards. General powers would be delegated to the Boards, subject to directions and regulations made by the Minister. Although aware of the logical inconsistency between complete Exchequer financing and local authority representation on Area Boards, nevertheless the Ministry felt that this was the only way that a take-over of local authority health services could be made acceptable, and that of sixteen members on each Board, the local authority's should appoint six, whilst the Minister would appoint nine, including the Chairman and four professions. The Ministry proposed that these members should be of a managerial type rather than the 'consumer representative' which tended to be found on Regional Hospital Boards. The possibility of a continuing local authority financial contribution was regarded as impracticable, and the Ministry felt that the Boards should be responsible for all local health and welfare services from the outset. To help meet the financial situation, it was suggested that the full cost of services transferred to central government should be offset against the Rate Support Grant. Financial control would be exercised as with the existing Regional Hospital Boards, with separate allocations to the Boards for the main blocks of expenditure.

This immediately raised issues on which the Treasury found it necessary to crystallise its views, and pressure was increased by the determination of the MHHD to engage in consultation with interested parties prior to publication of its Green Paper. It was clear that if the Treasury did not

take this opportunity of introducing its ideas into any major changes in the structure, it might well be many years before it again had the opportunity. Two issues absorbed the Treasury's attention, namely the financial implications, and the future relationships between the Health Departments and the NHS agencies in the field, particularly as in the latter case, the Treasury took the view that the Ministry tended to treat the existing Regional Hospital Boards with too much deference.

The financial issue turned essentially upon whether the Treasury was prepared to accept the transfer of the full cost of the local authority health and social welfare services to the Exchequer, and if so, the conditions under which this would be done. Alternatively, there was the question of whether or not it would be desirable or feasible to require a continuing financial contribution from local authorities. However, the latter possibility was rejected on the grounds that this would have undesirable implications for the membership and functional responsibility of the Area Boards, as local authorities would hardly agree to contribute without a substantial role in the management, which would blur the lines of accountability and responsibility, and possibly present problems of apportionment between local authorities. The first possibility also presented problems. Although transferring the cost to the Exchequer would not in itself represent any change, provided that the Rate Support Grant was reduced by an equivalent amount, so that the ratepayers should not be relieved at the expense of the taxpayers, and this was accepted by the Health Departments, nevertheless the

local authorities could be expected to raise strong objections, especially as it would involve them in loss of functions, and the Health Departments could be expected to attempt to placate the local authorities in other ways.

This latter point involved problems concerning the second issue, the relations between the Health Departments and the organisation in the field. The Treasury was greatly concerned to secure greater control and discipline in the operational management of the service, where it felt the Ministry had not exercised sufficient control. One possible solution to this problem which was canvassed in the Treasury at this time was to put the operational management of the service entirely in the hands of a central Board, like that of a nationalised industry, accepting that accountability could be regarded as subordinate to efficient management. This was rejected on the grounds that it would be unlikely to be acceptable to Parliament, where the accountability of Ministers for the NHS would be regarded as important and that in any event, there existed no objective measure by which to test the operational performance of the NHS in a way which was comparable to many nationalised industries. It was also likely that given the power of medical influence, any central Board would be likely to be weighted in favour of special, particularly medical, interests.

The same issue could, of course, arise in considering the membership of the proposed Area Boards. The ideal of the Treasury was therefore to aim at a full-time Area Board consisting of persons with appropriate managerial expertise. It was, however, recognised that this might initially be unattainable, though it was felt that the way should be left

open for evolution in this direction, and that the proportions of members allocated to the various interests should not be laid down in legislation, but by Ministerial regulation. The Treasury was prepared to accept initially sixteen members including a full-time Chairman, eight full-time administrators, three professionals, and four independent members, who would be part-time, all appointed by the Minister, although in the case of the four independent members, after consultation with the local authority or authorities. From the Treasury's point of view, the basic issue was to persuade the Health Departments that the proposed Green Papers had to emphasise improvements in management efficiency at least as much as organisational integration, and that the Area Boards would have to be composed accordingly.

It can be seen therefore, that from the Treasury's point of view, the Ministry of Health's proposals as they stood were less than satisfactory. Whilst these proposals took account of the need to integrate the tripartite structure in the interests of efficiency and the establishment of appropriate priorities, the Treasury felt that they did nothing about the largely autonomous status of the field agencies and the insufficient control and direction from the centre, nor about the composition of the managing authorities in such a way as to bring questions of efficient management adequately to bear or to counter the disproportionate degree of medical influence.

In seeking alternative proposals to offer, the Treasury quickly dismissed the notion of leaving the structure unchanged and relying on more effective co-ordination between

the field agencies and more positive control from the centre, as this would represent a lost opportunity. The idea of placing the NHS in the larger and more effective units of local government which were expected to arise from the work of the Royal Commission was also dismissed on the grounds that it would be unwise to introduce such a major change in local authority responsibilities at a time when they were in the process of re-organisation, and that unless a new source of revenue was found for local authorities, or the Exchequer contribution was increased, or complete responsibility assumed by central government for some major service such as education, it would not be feasible.

The idea of placing the NHS under an independent board[1], although one which might advance vertical control without impinging on the possibilities of lateral integration, offered no guarantee that it would secure more efficient management than any other possible arrangement. The Treasury therefore came back to the notion of managerial responsibility resting fully on the Ministry of Health, thus ending the semi-autonomous status of the field agencies, which would become completely answerable to the Ministry. However, the Ministry's proposals in their search for lateral integration, seemed likely to the Treasury to exacerbate the existing situation, and hence brought forward the proposal of managerial boards consisting of full-time members. It was recognised by the Treasury that at this stage, this was over-ambitious, as the medical profession would certainly object, and it might prove difficult to reconcile with the objective

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[1] See above, p. 149.

of securing lateral integration including a substantial part of the local health and welfare services. A further objection was the belief of the Ministry of Health that local authorities would have to be allocated a share in the management of the integrated service if their objections were to be overcome, and that an arrangement whereby, in common with other interests, they made their views known through a series of advisory committees to a strictly managerial board, would not be sufficient. It was therefore assumed that a take-over of local authority services on any scale into a laterally integrated Area Health Board structure would require some concessions in the shape of local representation on the Boards and some degree of continuing semi-autonomy. Thus, the Treasury was prepared to settle for a board of full-time chairman, eight full-time administrators, three professional members and four part-time independent members appointed by the Minister after consultation with the local authority or authorities, and that the way should be left open for evolution towards the Treasury's ideal by means of Ministerial regulation concerning the membership of the Boards.

The extent to which it would be possible to secure a result of this kind was clearly recognised as being dependent on the pressure exerted by the medical profession for representation, and the extent to which services were taken over from the local authorities. There would also arise at some time the necessity to make a judgement as to how far take-overs made in the interests of lateral integration might impede desirable improvements in vertical control, and there

was no doubt in the Treasury's view that in the event of conflict, the latter objective should prevail, even if, in the last resort, this meant that only the hospital and general practitioner services would be horizontally integrated and the local authority services were omitted. It was therefore, necessary to consider, in conjection with the Ministry of Health, how far it would be possible to achieve a compromise which would reconcile the objective of improved control and direction from the centre and the take-over of local authority services into the Area Health Board structure to improve efficiency. Clearly, therefore, options had to be kept open at this stage.

In May, 1968, a meeting took place at which the Treasury, DEA, Ministry of Health and DHSS were represented, to discuss issues arising out of the Treasury's comments on the draft Green Paper. These issues included phraseology which suggested that the proposals were less tentative than the forward by the Minister suggested; the boundaries of the take-over of local authority services and the necessity for a fuller discussion of the disadvantages as well as the advantages of this; the composition of the Area Boards, where in addition to the misgivings on the part of the Treasury, already outlined above, it was suggested that additional persons, presumably from local authorities might be added to the membership if the Area Boards became responsible for welfare services, and that there might also be university representation as recommended by the Todd Commission[1] with the result that the managerial members

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[1] Report of the Royal Commission on Medical Education, (Todd, Ch.), Cmnd. 3569, 1968, paras. 500 and 501, pp. 206-7.

might be swamped; the lack of reference to deficiencies in central control and the Minister's responsibility for promoting efficient management and securing value for money; and the proposal for an independent Commissioner for complaints, which the Treasury had not previously considered.

In June, 1968, the disagreements were elevated to the Ministerial Committee on Social Services, where on behalf of the Exchequer, the Minister of State[1] sought to remove any suggestion which might stimulate ideas that integration of the Health Services could be secured under the management of the new local authorities, to secure the future place of the local health and environmental services in the integrated structure, and crucially, that no commitment should be given concerning the inclusion amongst the membership of the Area Boards of a certain number of local authority representatives. However, little success attended these efforts, and indeed the revised draft which emerged was in some respects worse, from the Treasury's viewpoint. Thus, the alternatives of Area Boards or local authority management were presented as equally open for consideration, as a result of pressure from the Ministry of Housing and Local Government and the Home Office. Further, the suggestion that six members of the Boards should be the nominees of local authorities was reinforced and strengthened. It was therefore inevitable that the Treasury should take these crucial issues to the Cabinet for decision. It might be thought that presenting the local authority alternative as apparently open for

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[1] Mr. Dick Taverne, Labour M.P. for Lincoln.

seeking the approval of the Committee for setting in motion an urgent internal examination of the possibility of strengthening and improving the administrative structure of the medical and related services. It was also proposed to inform the Royal Commission on Local Government, the Seebohm Committee, and the Royal Commission on Medical Education, and to make a statement announcing the intention in the House of commons.

The Treasury was in no doubt that the review, and a public commitment to it, should be supported. The lack of effective co-ordination, management and control, and the notion that it did not offer value for money made such a review desirable in the Treasury's eyes, though it did not itself originate the suggestion[1].

By the end of November, 1967, an outline of what the Ministry wished to put in their Green Paper was available to The Treasury. It suggested some 40 Area Boards which would parallel the local authority structure which was believed likely to emerge from the report of the Royal Commission. It was envisaged that these Area Boards would be 100% Exchequer financed, and that there would be provision for a "democratic element" on the Boards. Beyond this, the proposals were vague about such matters as the relationship between the health departments and the proposed Area Boards, and on the question of the accountability and responsibility which would fall at each level. In February, therefore, the Treasury sought clarification of the Ministry's views at a meeting from which it emerged that the Ministry thought that full political and financial responsibility would be retained by

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[1] Much of the information for this section, particularly for pp. 146-156, was derived from material from a case study prepared for the Civil Service College, 1969-70.

of suggested changes in the draft Green Paper in order to focus discussion on the crucial changes. In the event, as a result of these discussions, the Treasury achieved its objectives as against the objections of the Minister of Housing to changes in the position of the local authority alternative, and the Minister of Health's views on local authority nominees to Area Boards.

Thus, the Minister of Health in his foreward to the Green Paper says,

> "It would not be appropriate to try to anticipate, in detailed discussion in this Green Paper, the effect of changes which might result from the Royal Commission's Report. But it must be recognised that a unified administration of health services under local authorities would raise major issues in relation to financing the integrated services, and one should certainly bear in mind the acknowledged difficulties of increasing local revenues and the problem of reconciling the continuing independence of local government with continuing and increased support from the Exchequer; such issues would call for extensive further consideration"[1].

With regard to membership of the Area Boards, assuming that paragraph 59 of the Green Paper was the crucial one at issue, it can again be seen that the Treasury gained its objective.

> "In general, it would be desirable to provide for flexibility in the size and composition of the membership of Boards, and room should be left for evolution. In order to bring direct experience of the practical problems of the services and to assist with the task of remodelling patterns of care, some members with broad professional knowledge of medical and related services would be needed, though it would not be desirable for these to be nominated to represent special interests. In areas containing medical schools the Minister might appoint on the nomination of universities one or two additional members. In addition, it

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[1] Ministry of Health, The Administrative Structure of the Medical and Related Services in England and Wales, 1968.

would be important to make arrangements to ensure that appropriate account was taken of the interests of local authorities. It is for consideration how this could best be done and this is a matter on which comment would be particularly valuable"[1].

Given the success enjoyed by the Treasury on the contents of the first Green Paper, the contents of the second Green Paper represented a considerable decline in the influence of the Treasury, if not quite outright defeat. Although the Health Service was to be administered by Area Health Authorities directly responsible to the Secretary of State, and not by local authorities, the area of the new authorities would be co-incident with the new local government boundaries, and the administrative boundary to be drawn between the NHS and the public health and personal social services would continue to be administered by local authorities. However, the serious aspect from the Treasury's viewpoint was that one-third of the membership of the AHA was to be appointed by the local authority, one-third by the health professions, and one-third by the Secretary of State. Local participation would be safeguarded by the creation of local district committees which would include local residents and professional staff[2].

One close participant said of this Green Paper, "the doctors and the Treasury hated it"[3]. Another observer described the proposals as "a time-bomb planted in the Treasury"[4]. Mr. Harold Wilson described the purposes of the

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1 Ibid., p. 20.

2 DHSS, The Future Structure of the National Health Service, 1970, paras. 53-59, pp. 16-17.

3 Lady Serota in an interview.

4 B. Abel-Smith, "The Politics of Health", New Society, 29 July, 1971, p. 192.

Green Paper as follows :

> "to unite the NHS and to integrate its separate local services - the hospital service and the GP service - on a local basis; to provide effective means for co-ordinating the NHS and the local government public health and social services; and to involve local communities in the running of the NHS district services. In consequence, this would decentralise responsibility to local services to the fullest extent compatible with central government responsibility for ensuring maximum value for the resources made available to it from resources contributed by the taxpayer and through the payment of National Health contributions".

The objective of more effective vertical control advanced by the Treasury was scarcely acknowledged. Mr. Wilson went on to say :

> "This had not been easy to get through. The Treasury had clung to the view that a hundred per cent ministerial appointments were needed to get full financial control. My own experience, from 1959 to 1963, as Chairman of the Public Accounts Committee, had convinced me of the opposite view"[1].

It is, of course, impossible to judge what the final outcome of these proposals would have been. In the event, the General Election of June, 1970, completely changed the situation as far as the possibility of the Treasury getting its views on re-organisation accepted was concerned. Shortly after Sir Keith Joseph assumed office, the entire future of the NHS became the subject of intensive investigation in Whitehall by an inter-departmental committee chaired from the Treasury[2]. Whilst there is nothing to suggest that any changes directly emerged from this committee, it must have served to acquaint Sir Keith Joseph with the rationale behind the Treasury's view of NHS re-organisation. It is

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[1] H. Wilson, The Labour Government 1964-70, Weidenfeld and Michael Joseph, London, 1971, pp. 764-5.

[2] The Times, 21 December, 1970.

also important to note here Sir Keith's close relationship with both the Chancellor, Mr. Antony Barber, and the Chief Secretary, Mr. Maurice Macmillan, both of whom had some experience of health matters, as Mr. Barber was a former Minister of Health, and Mr. Macmillan had been partly responsible for Conservative health policy in Opposition. Thus, £250 million (at current values) extra money, to be spent over four years, had been found for those parts of the health and personal social services concerned with the elderly and the mentally ill, by the end of 1971. This was entirely new money, and had nothing to do with capital or running costs. The real dimensions of this can perhaps be measured by the fact that the proportion of this new money which was to go on either providing new hospital buildings or treatment centres, or improving new ones in this area, represented a 50% increase on the resources already being provided by the DHSS for this purpose. This also represented a measure of the influence of Sir Keith Joseph in the Government and with the Chancellor and Chief Secretary, who were greatly assisted by his generally businesslike attitude to financing government spending[1].

It is not surprising, therefore, that Sir Keith should have had a more sympathetic view of the Treasury's aspirations in NHS re-organisation. This would help to explain the managerially neat structure and hierarchy from DHSS to district which Sir Keith established in his White Paper[2], and

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1 The Times, 25 November, 1971.

2 DHSS, National Health Service Re-organisation: England, Cmnd. 5055, 1972.

why, from his Consultative Ducument[1], he made few concessions which would weaken the centre, but rather tended to increase the regions in power. Not only would the administrative task of monitoring 14 regions be easier than that of monitoring the 72 area health authorities (outside London), but the ability of the centre to determine priorities in the allocation of resources would be enhanced. The continued emphasis on ministerial appointments to the authorities has been interpreted as a victory for the Treasury, in return for which Sir Keith obtained the extra funds for the NHS, and concessions on the use of funds which were recorded in the White Paper. Thus,

> "Authorities will have freedom, within limits, to use funds allocated for capital expenditure to meet revenue expenditure and vice versa. Arrangements will also be worked out to enable unspent revenue allocations to be carried over from one year to the next".

The makings of a bargain can be detected here[2].

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[1] DHSS, National Health Service Re-organisation: Consultative Document", 1971.

[2] R. Klein, N.H.S. Re-organisation: "The Politics of the Second Best", in The Lancet, 26 August, 1972, p. 420.

CHAPTER VI

The Role of the Pressure Groups: The Local Authority Associations.

(a) Introduction.

Willcocks, in his study of the establishment of the administrative structure of the NHS[1], has emphasised the role of the medical and local government pressure groups, notably the BMA and the Local Authority Associations, whilst acknowledging that "we may have undervalued, thereby, other important factors such as public opinion, ad hoc groups and so on"[2]. According to Willcocks, the groups with professional skills to offer, particularly the medical profession, achieved most in adjusting the original proposals. There was to be no local government control, no salaried service, only modified powers of direction, the removal of all hospitals from local government, whilst the consultant sector gained the regional bodies they wanted, special treatment for teaching hospitals, seats on administrative bodies, and no disciplinary machinery[3]. Local government, with an administrative structure and related skills to offer, was not in such a powerful position, and had to stress the advantages of democratic control and its previous achievements in the health field. Compared with the initial proposals, local government found itself in a far less satisfactory position, and lost its dominating position in

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[1] A. J. Willcocks, The Creation of the National Health Service, Op. Cit.

[2] Ibid., p. 102.

[3] Ibid., p. 105.

the health service. The third group, the voluntary hospitals, were in a powerful position as long as their property rights were respected, but once this ceased to be the case, and nationalisation was determined upon, the hospital groups "ceased to count and in this context lost all"[1].

The purpose of the next two chapters is to examine the objectives and tactics of the principal groups involved in the re-organisation of the NHS in order to attempt to determine their relative degrees of success and failure, the factors significant in the determination of success or failure, and the overall contribution made by the groups to the shape of the re-organised NHS, particularly in comparison with the assessment made by Willcocks of their relative achievements in the creation of the NHS.

The main techniques employed by groups in Britain have been outlined by Stewart[2], who has suggested that these may be divided into those which operate on Government, on Parliament and on the Public. Gable[3] has discussed the circumstances in which groups are most likely to succeed. He has emphasised the importance of the manipulation of acceptable cultural symbols by groups, such as those relating to democracy or professional clinical freedom; the social attitudes which establish expectations about particular groups and accord them relative status; the degree of access enjoyed to key points where decisions are made, and the

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[1] Ibid., pp. 106 - 7.

[2] J.D. Stewart, British Pressure Groups, Oxford University Press, London, 1958.

[3] R.W. Gable, Interest Groups as Policy Shapers, in Annals of the American Academy of Political and Social Science, Vol. 319, 1958, pp. 85 - 93.

ability of groups to turn access into influence by identifying their ideas with the prevailing attitudes of the relevant "prominent publics". The contribution of the Local Authority Associations and the BMA will be placed within this framework and the ways in which they pursued their objectives will be examined.

(b) The Local Authority Associations.

In announcing his decision to review the administrative structure of the NHS in the House of Commons on 6th November, 1967, the Minister of Health, Mr. Kenneth Robinson, made it clear that he did not intend to undertake consultations prior to the publication of his proposed Green Paper. In reply to a question from Mr. Will Griffiths[1], he said,

> "I do not think the Green Paper will be all that long delayed, but it will not be for some months. It will be after the publication of the Green Paper that we shall have the consultations. Whether any formal machinery will be required or desirable during the consultations is a matter which I would like to consider between now and publication of the Green Paper".

The effect of this announcement was to create quite genuine alarm within the Local Authority Associations. There was some reason for this. First, they had never accepted the proposals contained in the Porritt Report as a basis for re-organisation of the NHS, with their implication of medical domination of area health boards, and feared that the Government might come to some arrangement with the medical profession before local government had the opportunity to

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[1] Labour M.P. for Manchester Exchange. The question was "planted".

make its voice heard. Second, local government was currently engaged in fighting Mr. Robinson's proposals to put the Ambulance Service under the NHS, and some officials of the Associations thought, perhaps with hindsight rather than foresight, that Mr. Robinson hoped that this would provide a stepping stone to re-organisation[1]. It is not surprising, therefore, that local government regarded the lack of consultation prior to the publication of the Green Paper with some concern.

In addition to this concern, the Association of Municipal Corporations had lost no opportunity since 1946 to state its case for the establishment of an integrated NHS within the local government structure, but had experienced a long history of rebuffs at the hands of various inquiries, as well as from Ministers, on this issue. Thus, in July, 1953, an A.M.C. deputation had pressed the Minister, Mr. Iain Macleod, to restore the Hospital Service as a local authority responsibility, and had suggested that as an instalment, local authorities should be given greater representation on Regional Hospital Boards and Hospital Management Committees[2]. However, the Guillebaud Committee[3] was sitting at the time and the Minister was able to point to its existence as a reason for not considering these proposals at the time. Accordingly, the AMC mounted a

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[1] 738 H.C. Deb. 5s., cols. 379-80 and 751 H.C. Deb 5s., cols. 349-50, and Mr.T.A. Nelson, in an interview.

[2] Municipal Review, Supplement, 1953, pp. 291 - 2.

[3] Committee of Enquiry into the Cost of the National Health Service, (Guillebaud, Ch.). Its report was published in 1956 as Cmnd. 9663.

substantial body of evidence to this committee in favour of its ideas, but these were rejected in the final report on the grounds of financial problems, the objections of the medical profession, and the need for local authorities to expand the domiciliary health and welfare services[1]. The AMC also attempted to bring their case before two other bodies in 1954, the Committee on Economic and Financial Problems of the Provision for Old Age[2], and the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency[3]. In neither instance were its views accepted. Finally, in 1957, the AMC placed its views before the Cranbrook Committee on Maternity Services, claiming that local authorities should administer all branches of the Maternity Service, including maternity hospitals and maternity departments of general hospitals. Again, its views were not accepted[4].

The County Councils' Association was arguably more cautious and conciliatory in its approach to the re-organisation of the NHS than the AMC, and does not seem to have lent the AMC any specific support in the moves outlined above[5], although it similarly campaigned for the incorporation of the NHS into the local government

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1 Municipal Review, Supplement, 1953, pp. 241 - 2.

2 Committee of Enquiry into the Economic and Financial Problems of the Provision for Old Age (Phillips, Ch.). Its report was published in 1954 as Cmnd. 9333.

3 Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, (Percy, Ch.). Its report was published in 1957 as Cmnd. 169.

4 Report of the Maternity Services Committee (Cranbrook, Ch.), 1959.

5 M. Ryan, Reform of the Health Service Structure, in Public Administration, Autumn, 1968, p. 317.

structure. Probably this difference in approach stemmed from the fact that County Councils already had considerable health functions[1], and these had to be defended, and also they were heavily involved with the re-organisation of local authority social services under the Seebohm Report, with its implications for relationships with the health services, and for finance, management and manpower. It is also partly a question of style. Party politics entered less into CCA affairs than those of the AMC, and it tended to see itself giving a lead to other local authority organisations. It was, in general, Conservative dominated, and tended to convey a more affluent and well-ordered image. These factors doubtless influenced its approach.

Nevertheless, although the AMC changed hands politically during the course of the NHS re-organisation, there were no significant differences of view between the AMC and CCA over the main issues.[2] These were :

(1) to secure the return of the NHS to local government if possible;

(2) if this were not possible, then to secure maximum local government representation or presence in the new NHS structure;

(3) to ensure co-terminous boundaries between the health and local government authorities;

(4) to secure the greatest possible degree of collaboration between health and social services in the new arrangements;

(5) to safeguard the school health service.

Clearly, the attempt to secure the return of the NHS to the local government structure was chronologically

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[1] Including maternity and child welfare clinics, midwifery services, home helps and nursing, vaccination and immunisation arrangements, health centres, notification of births and infectious diseases, and ambulance services.

[2] Information provided by Mr. C.J. Berry in an interview.

the first issue to receive attention, and was emphasised in the memoranda sent to the Minister by both the Associations in an attempt to influence the Ministry's thinking prior to the publication of the Green Paper, in spite of the Minister's embargo on consultations. Given the alarm generated in local government, it is scarcely surprising that they should have done so. The memorandum from the AMC, submitted on 13th March, 1968[1] showed concern about the possible transfer from local government of the community health services. It suggested that the tripartite structure could be improved by joint policy machinery susceptible to democratic control through local representatives. It stressed the need for the review to be considered alongside local government reform, and was anxious that the concept of the Family Service should not be prejudiced by the divorce of the Medical Officer of Health functions from local authority welfare, education and children's services. The Association, it said, sought democratic control and accountability, with a view to securing the best deployment of available resources for development of the NHS. It refused to suggest a scheme for re-organisation on the grounds that local government reform was pending. The Association strongly adhered to the view that local authorities should remain responsible for community health services, and that the creation of new provincial authorities might well provide a basis for reconstitution of the Hospital Service.

Similarly, in April, 1968, the Secretary of the

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[1] Municipal Review, Supplement, 1968, pp. 207 - 9.

CCA[1] sent to the Minister a confidential memorandum identifying some of the more important factors and principles which the Association considered should be taken into account. The Association suggested that the case for administrative re-organisation was by no means certain, as many of the alleged defects of the NHS might be attributed to lack of manpower and resources. It indicated that it was aware of the changing pattern of medical care in relation to the growth of community care, the development of preventive and remedial measures which avoided lengthy stays in hospitals, and the more intensive and efficient use of hospital accommodation, and that these had implications for the future role of the general practitioner. It was also recognised that while these developments involved the integration of the health service, the need to promote effective relationships between medical practitioners and the social services was likely to become increasingly important, and that the extent to which family doctors in particular would be able to develop the social and preventive aspects of their work would be likely to depend on the closeness of their working relationship with the staffs of local authorities. The memorandum saw the position of local authority medical officers as being crucial to the development of this working relationship, regardless of whether the administration of personal social services was run separately from local health services as a result of the Seebohm Report. It was accepted that any prospective change would be unlikely to be acceptable to all

[1] Mr. A.C. Hetherington.

the professional interests, and that this might make revised arrangements impracticable, in which case the encouragement of co-operation was the only practicable course.

In considering the problem of finance and the weight of Exchequer contribution which might be required to make the transfer of the NHS to local government possible, and which might thus make local government responsibility illusory, the memorandum pointed out that a reduction in the number of local government areas following the report of the Royal Commission on Local Government in England would justify further consideration being given to the practicability of arranging for local government to tap new sources of revenue or to receive direct payment of part of the revenues now accruing to the Exchequer, and it was suggested that difficulties would only arise if such revenues were treated as central government grants, whereas if the diverted revenues were derived in the main from local sources there would be good reason for regarding them as local rather than as central government revenues. Stress was also laid on the need to make the hospital service more accountable at a local level without diminishing the drive to attain maximum efficiency in use of resources. It was implied that county councils, being for the most part large authorities, would be sensitive to local opinion in matters concerning hospital closures, for example, whilst recognising that some closures would be necessary in the search for rationalisation, and the Association's support for the new district general hospital policy was cited as

an illustration of their position. In conclusion, the Association noted that in any re-organisation, two conflicting arguments, both with a content of logic, had to be resolved. One argument, that of the specialist, was that the health service would be best controlled by a single authority whose main preoccupation would be with the hospital service. The other argument, likely to be that of the local administrator, was that the greatest overall benefit would be obtained where a single authority controls as many public services as possible, within a given locality.

> "This is the common argument of horizontal as compared with vertical integration. In the case of the Health Service neither argument should be pressed to its ultimate conclusion - but, because the care of health is only one aspect of a number of social needs, the closer it is possible to get to the horizontal form the more likely is the best result to be achieved in the overall interests of the 'consumer'"[1].

In its initial observations on the first Green Paper, which it emphasised were only preliminary pending possible action on the Reports of the Royal Commission on Local Government and the Seebohm Committee, the AMC stressed that its aim was to consider the Health and Family Services as a whole. Its desire to see the NHS restored to local government, or failing that, to see substantial local authority representation on the proposed health authorities was made clear.

The AMC indicated its general objections to the proposals by pointing to its evidence to the Royal Commission

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[1] Minutes of the Executive Council, October, 1968, p. 239.

on Local Government, where it had suggested there should be "local" authorities conferable to provincial authorities, to be responsible for health, welfare, children's and educational services, environmental health and housing, i.e. for personal social services which

> "if they are to be effective for the purpose for which they are established, must first ascertain and then endeavour to solve the problems on an individual or family basis frequently within a domestic setting. It follows that the services must be organised so as to secure a 'client-based' community health and social service".

In passing, it also directed a veiled thrust at the existing structure of the NHS in its evidence to the Royal Commission.

> "Whilst the Association appreciates that it is only existing local government services which are within the terms of reference of the Royal Commission and that it may not be open to it to recommend the transfer or return of services to local government, it is considered that an evaluation of the administration of services provided on a national basis in this manner might well be material to the work of the Royal Commission. The Association believes that if the efficiency and costs of providing essential local services by our present system of local government are under exhaustive examination, the alternative methods in use at the present time should be similarly examined and the public be made aware of the cost and other consequences which follow. To set against such an evaluation are the complete absence of local identification with such services and the tortuous and indirect nature of any democratic answerability for them"[1].

The Association found further support for its view in the Seebohm Report, where in paragraph 676, it says "we have arrived at the firm conclusion that a family service cannot be fully effective until the social service department and the housing, education and health departments are the undivided responsibility of the same local authority"[2].

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[1] Memorandum of Evidence to the Royal Commission on Local Government in England, October, 1966, para. 263, pp. 84-5.

[2] Report of the Committee on Local Authority and Allied Social Services, (Seebohm, Ch.), 1968, Cmnd. 3703.

The Guillebaud Committee was also cited by the Association in support of its contentions. This committee had examined the proposal that statutory ad hoc health authorities should be appointed on the lines of the existing RHBs to administer the three branches of the NHS. The committee, in rejecting this notion said:

> "It would moreover drive a wedge between the home health services now provided by local health authorities under Part III of the NHS Act and the Welfare services provided by local authorities under Part III of the National Assistance Act - a division which would in our view be calamitous. The aim in future should be to combine the local health and welfare functions as closely as possible and we could not give our support to any recommendations which would seek to tear them apart"[1].

The Ministry of Health's evidence to the Royal Commission on Local Government also provided ammunition for the Association's case. Thus, it was able to cite paragraph 27,

> "It is important to preserve the present links between the health and welfare services and child care and education and child care".

and paragraph 30,

> "The importance of the links between the personal health and welfare services and child care and education on the one hand and housing and environmental health on the other inclines the Ministry of Health strongly in favour of a re-arrangement of the present county and county borough areas into units covering both town and country administered by local authorities responsible for all these services".

The AMC indicated that apart from the importance of ensuring that the same authority is responsible for community health and family social services, the unification of the medical and related services outside the local government structure would create other new and undesirable boundaries.

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[1] Report of the Committee of Enquiry into the Cost of the National Health Service, (Guillebaud, Ch.), Cmnd. 9663 1956, p. 54.

At the end of its statement on general objections, the Association concluded,

> "It seems to the Association therefore, that the creation of area health authorities which are not also local authorities for housing, children, welfare and education will create new administrative boundaries, the disadvantages of which will outweigh the benefits (if any) which may accrue within the health service along".

In its general conclusions, the Association returned to its theme of restoring the health service to local government, and showed a tendency to dismiss the financial problems involved in a rather cursory fashion, which was to become typical of its approach to this aspect of re-organisation. It proposed that if the Royal Commission on Local Government were to suggest the setting up of provincial and local authorities, then the provincial authorities might well provide a suitable structure for the hospital service, and the local authorities would be suitable authorities for all the other medical and related services.

> "The financial considerations involved, to which the Minister makes reference in his Foreword, would need detailed discussion, but provided there were a general wish to make administrative arrangements of this nature there seems no reason to suppose that financial problems could not be overcome".

The Association felt that arrangements along the broad lines it suggested would have the following advantages :

(i) the health services would not be divided from other services to which they are closely related and in particular new and quite unnecessary administrative boundaries would not be set up between the community health services on the

one hand and the personal social services, housing and education on the other;

(ii) the health services would be the responsibility of substantial local authorities able to provide the many ancillary and supporting services which may not be readily available to boards concerned solely with the medical and related services; and

(iii) the health services would be placed in a democratic framework and those responsible for their operation would be answerable to the population whose needs they are serving.

Finally, the Association recognised two general objections. These were the known reluctance of the medical profession to work as part of the local government system, and the division of the health service between two tiers of local government. It concluded:

> "It is widely hoped that the legislation resulting from the report of the Royal Commission on Local Government will revitalise local democracy in this country and it would be retrograde in this context if the health services were not to be subject to local democratic oversight"[1].

The County Councils' Association in its comments on the first Green Paper became more specific in its views, and in spite of emphasising the need to consider the re-organisation of the NHS alongside the Seebohm Report and the Report of the Royal Commission on Local Government, and its objections to the timetable laid down for comment on the Green Paper, it ensured that its two basic objections to the proposals in the Green Paper were clearly indicated.

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[1] Municipal Review, Supplement, 1968, pp. 307-10.

These two objections were first, the undemocratic nature of the preferred form of area administration, and second, the inherent divorce of the medical from the bulk of the social services.

With regard to the first of these objections, the CCA took issue with the cursory treatment of the possibility of administering a unified service under a new type of local authority. The main point made in the Green Paper about this solution was that it would raise major issues of finance[1], and these were nowhere discussed in the Green Paper. The Association was at pains to point out in its memorandum to the Minister that the transfer of the NHS to local government on present cost allocation and within the framework of the existing financial structure would increase the percentage of relevant expenditure, for Rate Support Grant purposes that was met from national taxation from 55% to 69% which, it was argued, had no particular significance in relation to the degree of control by the central government over locally administered services and the continuing independence of local government. It was also suggested that, in any event, it was for the Government Departments concerned to see that local authorities were not relegated to the status of agents but were given every encouragement to exercise initiative and independence of judgement within the limits of national policy, and this would be much more readily achieved in the case of local authorities which were elected and partly financed locally than by Area Boards appointed by the Minister and wholly

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[1] See p. 6.

dependent on the Exchequer for finance.

Apart from the question of finance, the CCA expressed the view that the Area Boards' accountability to the public would be so indirect and incomplete as to give the public virtually no effective say as to the running of the health services in their local areas. It went on to say

> "Real public participation is essential to the organisation of the Health Service and maximum advantage should be taken of the benefits arising from local authority administration".

The benefits which were then pointed out included direct accountability to the public, local experimentation and initiative, effective expression of local democracy as a base for national democracy, the securing of a balance between the interests of the public and the professions, without prejudice to the independence of the medical and allied professions, the opportunity which would be given to the public to register complaints and influence policy, and the ensuring of local knowledge and interest, together with stimulation of local participation on a voluntary basis.

In its conclusion, the CCA did not feel able to put forward positive proposals at this stage either as to the extent to which services should be unified or as to their administration by local authorities, as the report of the Royal Commission on Local Government had not yet been published. However, it did reiterate with as much force as possible its complete opposition to the severance of the local health services from local democracy and from local authority social and related services.

> "It is their belief that local government is best able to provide a sound administrative basis both

> for serving the public and safeguarding the professional independence of the medical and allied professions. In the light of these principles, the Association consider that as much of the National Health Services as possible, and preferably all of them, should come within the ambit of democratically elected local government which already provides the bulk of social services".

The Association hoped the Secretary of State would withdraw the Green Paper proposals, and defer consideration of the re-organisation of the National Health Service until the Association and other organisations concerned could put forward and discuss other alternatives[1]. In the event, Mr. Arthur Jones[2] pressed upon Mr. Crossman local government's concern at the possibility of services being moved to nominated bodies rather than elected councils, particularly in view of expectations that the report of the Royal Commission on Local Government would lead to the devolving of responsibility from the Government. Mr. Crossman in his reply pointed out that the time for submitting views on the Green Paper had been extended to the end of January and said

> "As the Maud Commission's Report clearly must be considered before we come to a conclusion, there cannot be any harm in giving people more time carefully to reflect on the Green Paper"[3].

On 6th February, 1969 representatives of the Local Authority Associations met with Mr. Crossman to discuss re-organisation. The AMC representative (Alderman F. S. Marshall) argued that no case had been made out for a change in the structure of the NHS and that there should be no changes

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[1] Minutes of the Executive Council, December, 1968, p. 271.

[2] Conservative M.P. for Northamptonshire South and Vice-President of the Association of District Councils.

[3] 772 H.C. Deb. 5s., cols. 475-6.

before the Royal Commission on Local Government had reported. He suggested that there might be a case for the Hospital Service and the General Practitioner Services to be the responsibility of the local authorities, and that it would be necessary to safeguard the independence of doctors, which could be negotiated[1]. There were strong objections to services being run by appointed rather than elected members, and there were no grounds for transferring local health services to area health boards. The problem of the size of the Exchequer contribution was waved away as not being significant on the grounds that in some (unspecified) counties, 80% of the local authority expenditure was financed by the Exchequer without impairing local independence. It was not accepted that the Hospital Service had benefitted from being removed from local authorities in 1948. Their building programmes under 'forward look' had been developed at the expense of local health and welfare authority programmes which had been hampered by Central Government restrictions.

Likewise, the CCA representative (Sir Alan Lubbock) put the view that there was a need to keep the health services closely linked, and that if all health services were to come under local authorities, the participation of professional staff in policy-making decisions might become increasingly common, and the independence of the medical profession would be assured. On the whole, however, the Association were in favour of maintaining the present

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[1] In December, 1968, the AMC acknowledged the reluctance on the part of the medical profession to working as part of the local government system.
Municipal Review, Supplement, 1968, p.310.

structure and concentrating on the development of co-operation and co-ordination by local initiative with central encouragement[1]. In reply, Mr. Crossman assured the meeting that no decisions would be taken before the report from the Royal Commission on Local Government, which he had not yet seen.

On 28th February, 1969, Mr. Crossman made a speech at Norwich[2] which was interpreted by the General Purposes Committee of the AMC as strengthening its hand. Accordingly, it proposed to send to the Secretary of State a further paper on the need to preserve and extend if possible the democratic control of health services, and with this in mind, to maintain local authority responsibility for their administration. In the Norwich speech, the Secretary of State had proposed to set up a working party on revised proposals based on a two-tier structure. It was suggested that the Secretary of State had accepted that personal services such as Health should not be administered by bodies remote from the consumer, hence the two-tier system. The AMC in its initial observations on the first Green Paper had suggested a two-tier structure. It was further encouraged by the Secretary of State's silence about the relationship between the Health Service and local government. The AMC therefore stressed that if the Secretary of State were genuinely concerned to ensure that administration did not become remote from the patient, the best course would be to place the services in a framework in which the interests of the users were represented by elected men and

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[1] Minutes of the Executive Council, May, 1969, pp. 109-110.

[2] Reported in The Times, 1 March, 1969.

women answerable locally. It went on to urge not only a structure based on local accountability, but that consumer interests could not effectively be represented by nominees of the Minister or by consultative committees. Here, the old grievance of the paucity of local authority representatives on RHBs and HMCs was raised. The Association was now able to point to the need for co-ordination of local authority social services and medical services for the elderly and the mentally and physically handicapped, as recommended by the Seebohm Report[1]. Clearly, at this stage, the AMC was still advancing its position with regard to integrating the NHS into the local government structure, but was carefully maintaining a fall-back position with regard to substantial local authority representation in the event of defeat.

In an addendum to the paper, the General Purposes Committee added further weight to its arguments in seeking to appear conciliatory in face of recently expressed opposition to unification of the NHS within local government by the BMA[2]. It re-emphasised its view in favour of the unification of the health services within a re-constructed local government system, and stressed that the administrative structure should be based on a partnership between locally elected people and the medical profession whose independence both clinically and, where appropriate, as contractors, should in no way be impaired. It felt there was nothing incompatible in this concept. The paper concluded:

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[1] Municipal Review, Supplement, 1969, p. 131.

[2] British Medical Journal, Supplement, 8 February, 1969, pp. 55 - 68.

"If, as seems probable, the future areas of local government will be convenient for the administration of the health services then in the Association's view a means should be found to place the health services within the local government system and upon a truly representative and accountable framework. At the same time the arrangements made must be ones which will not damage the professional independence and standing of medical and allied professions, and which offer to the professions some scope for direct participation in the planning and administration of the service"[1].

It is not surprising therefore, that the Association expressed extreme disappointment with the second Green Paper put forward by Mr. Crossman.

"The document is a great disappointment to the Association. Last week's White Paper on local government reform suggested that it would not be practicable to unify responsibility for the NHS within the new system of local government but no explanation was given to justify the alleged impracticability.

The Green Paper seeks to defend the Government's decision on the grounds of professional opposition and the inadequacy of independent financial resources of local government. It remains the Association's view that it would be wholly practicable and highly desirable for a number of reasons to unify the health services within a reformed structure of local government"[2].

In its official observations on the second Green Paper, the Association re-affirmed its position.

"It remains the Association's view that the unified health service should be the responsibility of reformed local government. This view was not only expressed by the Association but by a number of other bodies, notably the Royal Commission on Local Government in England. The report of the Seebohm Committee also presupposed a situation in which the health services were the responsibility of local authorities. The second Green Paper in rejecting administration of the NHS by local government is therefore a disappointment to the Association and a blow to local government generally".

It went on to repudiate the two reasons given by

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[1] Municipal Review, Supplement, 1969, pp. 214 - 5.

[2] Municipal and Public Services Journal, 13 February, 1970, p. 351.

the Green Paper for the rejection of local government. First, it was suggested that the Professions believed that only a service administered by special bodies upon which they would be represented would provide a proper assurance of clinical freedom. The Association replied,

> "It is surely for the Secretary of State to decide whether a belief of this sort has any justification rather than to put it forward as being in itself a ground for a particular course of action".

Second, it was suggested that the independent financial resources of local authorities were insufficient to enable them to take over responsibility for the whole health service. In reply, the Association pointed out that in practice a larger part of local government expenditure is already met from Central Government than from rates, and that a Green Paper on local revenue was due later in the year. It was quite wrong for the Government to conclude in advance of that Green Paper and the subsequent discussions that it would not be possible for adequate financial arrangements to be made for local authorities to take over responsibility for the health service. It indicated that public expenditure on education exceeds that on the NHS and local authorities with the aid of the rate support grant are responsible for more than 80% of the expenditure on education; similar arrangements could be made for the NHS, for example, by the assignment of a portion of the National Insurance yield in addition to the general grant. The decision on the future structure of the NHS should not be based on purely financial considerations - "these are secondary". The Association urged the Government "to

reconsider the whole question in the context of a reformed system of local government"[1].

The CCA was likewise disappointed although it acknowledged that the second Green Paper was an improvement on the first. In its preliminary views it re-stated the view that proper professional freedom could as well be assured in a local government context as under Whitehall, and that there were no insuperable problems involved in allocating to local government adequate financial resources or in providing local government with independent resources.

> "The reasons given in the Green Paper for rejecting the Redcliffe-Maud Commission's views may well be rationalisation for decisions taken on other political grounds but this possibility makes them, if anything, less convincing"[2].

In its second memorandum on the Crossman Green Paper, the CCA re-asserted its view that, in general, all local services should be administered by local authorities and that, in particular, local government was best able to provide a sound administrative basis for the health services in a manner which would both serve the public and safeguard the professional independence of the medical and allied professions. It argued that the NHS, together with related social and other local services should be within the ambit of democratically elected local government.

The advent of the Conservative Government in June, 1970 saw the end of any possibility of local government control of the NHS. In reply to a question in the House of Commons on 5th November, 1970, Sir Keith Joseph

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[1] Municipal Review, Supplement, 1970, pp. 159-160.

[2] Minutes of the Executive Council, March, 1970, p. 74.

indicated that he intended to unify the structure of the NHS outside the local government structure by means of health authorities working closely with local authorities responsible for personal social services and the public health service[1]. Both the AMC and the CCA wrote immediately to the Secretary of State expressing their regret, and the AMC in particular expressed dismay that Sir Keith Joseph made such a firm statement without pursuing with the AMC the arguments already advanced for re-organisation within, or in a more satisfactory relationship with the local government structure after re-organisation. From this time onwards, the energies of local government were directed towards obtaining their objectives in relation to the details of re-organisation. Thus, the secretary of the AMC "assumed the consultations promised were to permit detailed exploration of the closest possible working relationship which the AMC wished to see" and expressed the hope that no more time would be lost before the examination of all possible ways in which the unified NHS could be incorporated with the work of local authorities was pursued[2].

From the Local Authority Associations' side, the question of local government control of the NHS was only fleetingly raised thereafter. The AMC, in its observations on the White Paper[3], remarked,

> "As the decisions contained in the White Paper are, in the main, firm ones it would not serve any useful purpose for the Association to re-open the question

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1 805 H.C. Deb. 5s, cols. 437-9.

2 Municipal Review, Supplement, 1971, pp. 15-16.

3 DHSS, National Health Service Re-organisation: England, Cmnd. 5055, 1972.

> of integration of the NHS within local government. The Association must, however, record its regret that unification is to take place outside local government and must express the hope that at some time in the not too distant future it will be possible to re-assess the obstacles which are said to lie in the way of bringing the NHS within the ordinary framework of local government"[1].

Lord Milverton[2], putting the local authorities' case on the Second Reading of the Re-organisation Bill, suggested that both patients and the public in general would benefit from the administrative unification of the NHS with local government, and supported his argument with a quotation from paragraph eight of the English White Paper.

> "There are very strong arguments for bringing health and social services under a single administration. This could be accomplished by putting the NHS within local government. But, for reasons accepted and fully explained by both the previous and the present Government, that is not attainable, at least in the foreseeable future".

He went on,

> "It is noted, however, that the possible future integration of the NHS within local government is not ruled out, and the associations believe that the obstacles which are said to lie in the way of this solution should be reviewed from time to time"[3].

Although the Local Authority Associations were well represented in Parliament through their system of vice-presidents, who received a joint briefing paper prior to the introduction of the Bill in the House of Lords, they did not place a high valuation on their activities in relation to Parliament. One participant said "We had stopped fighting"[4]. Another said, "We didn't do very much. The Bill was not framed in such a way to make this possible.

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[1] Municipal Review, Supplement, 1973, pp. 16-18.

[2] Vice-President of the AMC.

[3] 337 H.L. Deb. 5s., col. 102.

[4] Mr. T.A. Nelson (CCA) in an interview.

The main consultation was done on the Consultative Document and White Paper when the main pattern was laid down. Another remark was "We made the best of a bad job"[1]. It had become clear that the basic structure had been settled, and local government re-organisation was demanding attention.

Ironically, the Labour in Opposition espoused the cause of placing the NHS within local government. However, it was difficult for Labour to stress the point effectively as in their two Green Papers, they themselves had not taken the opportunity. The justification for the new position was that the situation had been changed by the reform of local government and the creation of larger more viable, units. As one political participant put it "We changed our minds. Crossman has changed his views since the second Green Paper, largely because of regional possibilities[2]. However, the weakness in this argument was that no new source of finance had been found for local government, and that local authorities would therefore be controlled by the need for central government finance, although the examples of housing and education could be cited in repudiation of this idea. Nevertheless, the Labour argument rang a little hollow, and there was the question of medical attitudes to be considered. Paradoxically, both parties agreed on the essential desirability of integrating the NHS into local government. As Sir Keith Joseph put it in introducing the Second Reading debate in the House of Commons,

> "No doubt in a perfect world .... the answer would be to unify the health services within local government. That would provide what many of us

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[1] Mr. C.J. Berry (AMC) in an interview.

[2] J. Silkin, "The Politics of Integration", lecture given at the London School of Hygiene and Tropical Medicine, 18 February, 1974.

would like to see in a perfect world, namely, one decision-making authority in every area, with one budget. But we do not live in a perfect world, and that is not practicable. The Labour Government did not believe, nor do this Government, that it is practicable to unify the health services within local government"[1].

The contribution of the Labour Party was not highly regarded in local government circles. One commentator suggested that the Labour Party's position had more to do with being in or out of government than with any issue of principle[2]. A local government participant remarked:

> "A Labour Minister with reforming zeal is reluctant to put it into the hands of local government. They resist it as slow and liable to thwart their desires especially when of opposite political view. One finds the Labour Party more centrally-orientated than the Conservative Party. When it comes down to getting something done they don't want local authorities to do it, they want some central body to do it. Labour is even more impatient of local authorities than the Conservatives. Their support was because they were in opposition"[3].

The question remains to what extent the local government bid to take over the NHS was both real and realistic. There is no doubt that the BMA thought it was real and reacted in alarm[4]. On the other hand, even Crossman, who was prepared to give relatively more emphasis to the representational aspects of re-organisation than the managerial aspects did not find it possible to hand the NHS over to local government. Local government itself was probably ambivalent. It had long been aware of the

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[1] 853 H.C. Deb. 5s., col. 926.

[2] R. Klein, Policy Making in the National Health Service, in Political Studies, March, 1974, p. 10.

[3] Mr. C.J. Berry (AMC) in an interview.

[4] British Medical Journal, Supplement, 1969, pp. 58-9.

financial problem. As one prominent local councillor had put it,

> "Local Government barely sustains its present responsibilities. It could not consider undertaking major new ones, or accepting the return, seriously needed on a variety of grounds, of the hospitals service"[1].

Arguably, however, the financial problem could have been solved had the will to do so been present, but the views of the Treasury meant that this was not a possibility. The Local Authority Associations pushed the view that the rate support grant was local money returned to the locality. The medical profession was also intransigently opposed to local government control of the NHS.

There were also the views of the Ministers concerned to be taken into account. The first Minister was considered by one local government participant to be opposed to local government. "I don't think Kenneth Robinson was a local government man at all. It never was in him at all". Sir George Godber[2] was also regarded as strongly anti-local government. Crossman was regarded as more favourable to local government, and the Local Authority Associations considered themselves to be partly responsible for this. "Crossman was prepared to think of the bodies as representational as well as managerial" was one comment. The same participant indicated that Sir Keith Joseph "sat on the fence for a very long time before he came down for nationalising the NHS. He wanted us to make a case for resisting Labour's proposals. If we had had the support of the medical officers of health we might have pulled it off.

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[1] Mr. Edmund Dell (Manchester Finance Committee)

[2] Chief Medical Officer at the Ministry of Health and the DHSS, 1960-73.

But they had a death wish". Another comment was :

> "I don't think it was ever contemplated by Whitehall. The key was the medical officers of health. Once Godber got them to see that they had no future in local government no-one else ever bothered very much. From then on we were not very effective in spite of great effort"[1].

In fact, study of the exchanges between the Ministry of Health and the Treasury prior to the first Green Paper indicates that local government was not considered a really serious possibility for unification of the NHS and that any encouragement offered by the first Green Paper was largely tactical. Certainly the professional administrators of the Local Authority Associations were under no illusions about the difficulties. As one said, "It became a numbers game to get representatives. I couldn't say we were very successful"[2].

Once it had been established finally that the NHS was not going to be unified within local government then the numbers game began in earnest, although from the start the ground had been prepared for this eventuality. Local Government representation on health service administrative bodies was sought for two reasons. First, there was the need to secure effective co-operation between personal social services under local authorities and the health service, and local authority representation within the health service administration was argued as one way of achieving this. Second, there was arguably a need to secure an element of democracy in the NHS such as might be supplied by local government representatives, and also a need for some form of consumer representation which was later to be secured by the creation of community health councils on

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[1] Mr. T.A. Nelson (CCA) in an interview.
[2] Mr. C.J. Berry (AMC) in an interview.

which local government has some representation. It is difficult, of course, to determine how far the claims of local government to be able to provide an element of democracy and consumer representation in the NHS are valid and how far they are rationalisations of a desire for a greater degree of involvement in lieu of local government control.

In its response to the first Green Paper, the AMC expressed its desire to see the Health Service restored to local government, "or failing that, to see substantial local authority representation on the proposed health authorities". It continued later, "The Association believes that in considering the future of the health services generally the first consideration must be to find a structure which makes them more responsive to the needs of the population they are intended to serve"[1].

Following the publication of the report of the Royal Commission on Local Government in England[2] in June, 1969, parallel discussions took place between first the Secretary of State for Social Services, the Home Secretary, the Secretary of State for Wales and the Paymaster General on the one hand, and the Local Authority Associations and Greater London Council on the other, and second, between the Secretary of State for Social Services, the Local Authority Associations and the BMA. These discussions took place between July and October, 1969.

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1 Municipal Review, Supplement, 1968, p. 309.

2 Report of the Royal Commission on Local Government in England, (Redcliffe-Maud, Ch.), Cmnd. 4040, 1969.

At the first set of discussions, the Local Authority Associations pressed the point that if the NHS were to be re-organised outside local government then this could lead to fragmentation because there would be a division between the health service on the one hand, and the personal social services and the education service within local government, on the other. It was also argued that this would be against the spirit of the Royal Commission on Local Government. However, the Local Authority Associations indicated that if a real place could be found for local government in a re-organised health service structure in such a way as to give local authorities an effective say in its management then they would be prepared to co-operate. From the parallel set of discussions with the BMA, it was indicated that areas had emerged in which further discussions might be fruitful.

During the meetings with Ministers, the Local Authority Associations outlined a staged solution which they felt might prove desirable, which would involve legislation on the Seebohm Report to include only the children's and welfare services, so that the future of the local authority health services could be tied in with the re-organisation of the NHS[1]. The Government at this time would have preferred to consider the various re-organisations which were pending as a whole, but would not permit delay to rule out the possibility of legislating on Seebohm in the coming session. It was clear that by this time the Secretary of State had ruled out the possibility of finding a long-term

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[1] County Councils' Association, Minutes of the Executive Council, 1969, pp. 272-4.

settlement of the problem of NHS administration, and felt that some kind of interlocking administration of the service would serve immediate needs.

Meanwhile, as a result of the meetings with the BMA, the Local Authority Associations had concluded that the unification of the NHS within local government would be unacceptable to the medical profession, and therefore took part in further discussions with the Secretary of State to explore the notion that the health service might be unified in such a way as to leave it neither wholly inside nor wholly outside local government, so that local government might be given a substantial share in the administration of any proposed unified service. The BMA also took part in these discussions and "By the end of the year, these discussions had disclosed many areas of agreement and publication of the three documents referred to was expected at an early date"[1].

Given the optimism generated by these discussions, the publication of the second Green Paper proved a great disappointment to local government, although it was acknowledged to be an improvement on the first Green Paper. The AMC expressed the view that

> "the membership proposed for the new area health authorities is not sufficiently representative of the public. The Government will recall that the following view was expressed in paragraph 366 of the report of the Royal Commission on Local Government in England. If there should prove to be any reasons why nominated boards should run the NHS, the new local authorities should at least appoint a substantial proportion if not a majority of the board members. At the core of each board

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[1] 80th Annual Report of the County Councils' Association, March, 1970, p. 96.

> will be a powerful professional bureaucracy. The body to which that bureaucracy is responsible should contain a strong contingent of elected representatives aware of popular opinion and sensitive to it. It is interesting to see that nowhere in the Green Paper has the Government referred to this recommendation or explained why by offering only one-third representation to local authorities they have ignored it".[1]

The CCA commented :

> "The reasons given in the Green Paper for rejecting the Redcliffe-Maud Commission's views, may well be rationalisations for decisions taken on other political grounds but this possibility makes them, if anything, less convincing"[2].

The Local Authority Associations took the same line when the Consultative Document was published. The AMC stressed the need for a responsive and adequate health service in every area of the country. It argued that it followed from this that a substantial proportion of members of the area authority - at least half - must be appointed by the corresponding local authority. Although the Association agreed that the number of members should be kept small, it thought that fourteen might well be too few and that 25 would be more adequate, especially in view of the very large areas proposed.

It was argued that local authority representation should be increased for three reasons. First, to speak for the patient - indeed it was pointed out that the patient was barely mentioned in the document at all. Local authority representatives would not owe their position to the goodwill of those running the NHS.

> "It is not apparent that nominees will be able to voice views of the public with the independence

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[1] Municipal Review, Supplement, 1970, p. 160.

[2] Minutes of the Executive Council, March, 1970, p. 74.

> with which it should be voiced. It is quite clear members of RHBs do not behave in this way (i.e. question what is being done) and if they do may find themselves no longer required to serve".

Second, it would help cement operational links at various levels. Third, it was argued that preventive medicine should have a stronger voice than hitherto in the total allocation of NHS resources and the claims of community care should have equal consideration with the claims of hospital care. Local authority members should assist in this process.

The Association went on to suggest that the same considerations applied to regional authorities, even though there would be no co-terminous single local authority. It was argued that elected local authority members should comprise at least half the members of regional councils and should be appointed by local authorities and not nominated by the Secretary of State. There should be at least one nominee from each county and metropolitan district council within the region[1].

The CCA took a similar view.

> "The Association regard local authority representation at both area and regional levels as essential. At regional level the numbers involved may preclude the representation of all local authorities in every region but it should be quite possible to arrange suitable joint appointments.
>
> At both levels, the importance of the relationship suggests the need for at least one-third of the members to be local authority representatives. This would be consistent with the corresponding proposal in the Second Green Paper".

Whilst accepting the importance of management ability, the

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[1] Municipal Review, Supplement, 1971, pp. 154-6.

Assocation doubted whether it should be regarded as a principal criterion for the selection of members of health authorities, as in its view

> "public representatives should be concerned with the public not only in an abstract sense, but also in terms of personal contact. Health authorities far from being insulated from public opinion, should preferably be more sensitive to it than other public bodies providing impersonal services"[1].

The AMC reiterated much of its criticism when commenting upon the White Paper. It again argued that authorities of around 15 members would be toosmall and that the members themselves would have too limited a background of local knowledge to discharge their responsibilities. It also criticised the notion that the needs of the NHS could best be met by choosing members for "their personal qualities after appropriate consultations". The Association's view was that in the main, area and regional health authorities should consist of elected representatives of local authorities who would be in the best position to exercise independent judgement.

> "The suggestions made in the White Paper are not only unfortunate for the NHS but represent a perpetuation in British life of a principle of patronage and self-selection whichis outdated and harmful to the fabric of democracy. It is also a process which will tend to place far too much power in the hands of the permanent officials at the expense of the lay representatives"[2].

The CCA likewise indicated its dissatisfaction with the extent of the proposed local government representation on area health authorities and the lack of any representation

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[1] Minutes of the Executive Council, July, 1971, p. 195.

[2] Municipal Review, Supplement, 1973, p. 17.

on regional authorities[1].

When the Re-organisation Bill came before the Lords, the Local Authority Associations through their Vice-Presidents put great pressure upon the Government to make greater provision for local government representation on the health authorities. On the debate on the Second Reading, Lord Milverton stressed the view that authorities of 15 members were too small and that both area and regional authorities should consist in the main, of elected representatives of local government[2]. In committee, it was possible for separate amendments to be moved relating to the membership of regional and area health authorities and the Labour Party added to the pressure being applied by local government. Lord Brooke of Cumnor moved an amendment to give local authorities five representatives on regional health authorities, whilst Baroness Serota moved an amendment to give local authorities one-third of the representation on regional health authorities. However, Lord Aberdare rejected these amendments on the grounds that regional health authorities were not intended to be representative of local authorities and the health care professions. He felt that it was impracticable to reduce the Secretary of State's appointments to regional authorities to one-third of the total membership[3]. On Report, Baroness Serota again attempted to provide for one-third of the membership of

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1 Minutes of the Executive Council, October, 1972, p. 235.

2 337 H.L. Deb. 5s., col. 101.

3 338 H.L. Deb. 5s., col. 34.

regional authorities to be appointed by named local authorities within the region, whilst Lord Brooke of Cumnor and Viscount Amory put an amendment to ensure that four or more serving local authority councillors from the region would be appointed to the regional health authority. Again these amendments were rejected, this time by Lord Brown for the Government. He argued to Baroness Serota that regional health authorities were accountable to the Secretary of State and therefore must be appointed by him or else they would be accountable to someone else. He pointed out in reply to the other amendment that the Secretary of State was obliged by the Bill to consult local authorities before making appointments to regional health authorities, and that there would certainly be people with local government experience appointed and that statutory provision was unnecessary[1].

At the Committee stage in the House of Commons, Mr. John Silkin made a last effort to secure that half of the members of regional authorities would be appointed by local government and half appointed by the Secretary of State, having regard to persons employed in the NHS, and that the chairman should be elected from amongst the members at the first meeting of the authority. Whilst admitting that the local authority members on regional health authorities might find themselves in a dilemma, Mr. Silkin argued that such a provision would give local authorities experience for the day when the NHS became locally administered. "If we are moving - at whatever tempo - towards a

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[1] 338 H.L. Deb. 5s., cols. 1402-28.

locally administered NHS, it is right that the local authorities should have the greatest possible experience for when that day comes". Mr. Michael Alison[1] rejected this on behalf of the Government on the grounds that the Secretary of State is accountable and must therefore be in a position to nominate and control. Local authority representatives were present on area health authorities to ensure co-operation and co-ordination specifically and not to ensure democratic representation, and they had no members on regional health authorities as there was no matching local government authority, although the Secretary of State retained the right to have them on the regional health authority if he wanted. He also pointed out that four out of 15 members (on area health authorities) as opposed to 50% of membership was a difference in kind and not a difference of degree, as 50% would make two statutory blocks, whereas four would not be expected to represent local government in the same way[2]. The amendment was duly negatived, and the Local Authority Associations had to be satisfied with the assurances of representation at regional level rather than statutory recognition of a right, and the knowledge that the membership of area health authorities was determined by regulation, not statute, and that the Labour Party was pledged to improve their representation.

Another aspect of local government concern with its representation within the re-organised NHS centred upon the

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[1] Joint Under-Secretary of State, DHSS.

[2] Parliamentary Debates, House of Commons Official Report, Volume 5, 1972-3, Standing Committee G, 3 May, 1973, cols. 435-488.

comunity health councils. These first appeared in the Consultative Document in place of the shadowy local district councils which were included in the second Green Paper. The Community Health Councils were recommended for each constituent district, but would not be directly representative of local interest, which would have led to a "dangerous confusion between management .... and the community's reaction to management". The new area health authorities would be required to set up community health councils in each health district and to appoint the council members "after consultation with a wide range of interested local organisations"[1]. The reactions of the Local Authority Associations came in three forms. First, they argued that local authorities could readily perform the functions of community health councils which were therefore superfluous. Second, they sought to gain some measure of control over community health councils. Third, they sought to gain maximum possible representation upon the community health councils.

The AMC in its comments on the Consultative Document rejected the dichotomy between management and the community's reaction to management. It suggested that community health councils should be broadly based, and if they could receive and investigate complaints, could be useful in a small way[2]. The CCA also expressed doubts about the effectiveness of the proposed community health councils.

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[1] DHSS, National Health Service Re-organisation, Consultative Document, 1971, para. 20, p. 10.

[2] Municipal Review, Supplement, 1971, pp. 154-6.

> "As a management device for appearing to deal with public criticism, "users'" councils can serve a purpose but their usefulness to the public is not always real.
>
> This proposal is greatly weakened by the suggestion that appointments to the council should be the responsibility of the area health authorities with power to remunerate their chairmen. The paragraph refers to safeguards, but whether it is the public or the area health authority which will be safeguarded is not clear. From the point of view of the public the effectiveness of any community health councils will depend on the independence of the members and the strength of the Secretariat. The Association doubt whether it is practicable or desirable to attempt to recruit paid staff in the number and of the calibre required to service community health councils effectively.
>
> Consideration should be given to the possibility of enabling local authorities to appoint and service the Councils or to set up or nominate one of their own committees (suitably augmented with representatives of other bodies) to exercise the suggested community health council functions"[1].

In the time between the Consultative Document and the White Paper the Government moved away from the suggestion that the area health authority should appoint members of community health councils, in response to criticism from local government and elsewhere. The AMC was able to regard the proposal to set them up as constructive, and felt they would have useful work to do, but "there is no reason why representative capacity should be concentrated in this one body. The suggestion that half the members of the community health council should be chosen by district councils within the area and the other half on the nomination, in the main, of voluntary bodies is reasonable and should ensure a vigorous and independent group. The upper limit could

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[1] Minutes of the Executive Council, July, 1971, p. 196.

generally be 30 and for some districts a smaller number may suffice". The Association then turned to two aspects of community health councils which were to continue to bother it. First, there was the problem of access to health officials.

> "It is important, however, that the community health councils should have access not only to senior officers administering district services but to senior officers and members responsible for area services - especially as the White Paper insists that the main responsibility will be that of the area health authority".

Second, there was the principle of the independence of community health councils.

> "In the Association's view the community health councils will operate far more effectively if the secretarial staff and accommodation for meetings is provided by one of the main local district councils in the area and not by the area health authority or by the matching metropolitan district council. Such an arrangement would provide some guarantee that the public interest would be fully reflected in the choice of matters to be discussed and in their presentation"[1].

The CCA also made proposals for the servicing of community health councils by local authority staffs[2].

When the Re-organisation Bill came before Parliament, the Local Authority Associations were concerned therefore, to strengthen the role of community health councils, secure their independence and to obtain strong representation upon them for local government. This involved, essentially, ensuring that area health authorities did not nominate members to community health councils and that they

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[1] Municipal Review, Supplement, 1973, pp. 17.

[2] Minutes of the Executive Council, July, 1971, p. 196.

did not provide the necessary staff and accommodation. With regard to the first matter, there was comparatively little difficulty. Baroness White made the point on Second Reading that half the members of community health councils should be appointed by local government district councils and that the community health councils should appoint their own staff[1]. This was taken up in an amendment put in Committee by Viscount Amory which suggested that community health council members should be appointed by local authorities and the staff appointed and paid also by local authorities. There was also a suggestion that county councils should have one or two members[2]. Lord Aberdare for the Government readily conceded that half the community health councils were to be appointed by district councils and that each district should be represented on the appropriate community health councils, which were to bebased on health districts. Thus, the area health authority could not appoint a majority on the community health council. Two-thirds of the remaining members of the community health council were to be appointed by the area health authority in consultation with local voluntary bodies who would put forward names, and the remaining one-sixth would be other local people from various organisations with interests in the health services, such as the churches[3]. However, Baroness White attempted to get responsibility for receiving nominations from organisations placed as to specified local

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[1] 337 H.L. Deb. 5s., col. 121.

[2] 338 H.L. Deb. 5s., col. 105.

[3] Ibid., cols. 109-10.

authorities, and Viscount Amory had framed an amendment to enable district councils to do this. Lord Aberdare indicated he was prepared to think about this, especially if the authority receiving nominations were to be county councils, and he would have consultations with local authorities about this[1]. However, when he brought the question of community health councils back on Third Reading, he was able to say "we have re-cast the whole set-up as far as community health councils are concerned"[2], and the regional health authority was put in the place of the area health authority as far as non-local government nominations was concerned.

The second issue, the servicing of community health councils, proved to be more difficult. At the Committee Stage in the Lords, Lord Bridgeman and Lord Garnsworthy were quick to point out that Lord Aberdare had not taken Viscount Amory's point made in his amendment concerning the appointment and payment of community health council staff by local authorities. As Lord Garnsworthy put it,

> "The Government does not grasp the point about complete independence of community health councils, and therefore came up with an answer unacceptable to public opinion and to local authority associations"[3].

The issue was again raised at the Committee Stage in the House of Commons, when Mr. George Thomas and Mr. Arthur Blenkinsop attempted to ensure that the community health councils would have a secretariat quite distinct from that

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[1] Ibid., cols. 121-2.

[2] 339 H.L. Deb. 5s., col. 527.

[3] 338 H.L. Deb. 5s., cols. 111-14.

of the area health authority. He also put an amendment designed to exclude the danger of all staff and premises for community health councils being provided by area health authorities[1]. This was rejected on the grounds that there might be occasion when it would be sensible for the community health council to use premises provided by the area health authority, and when it might wish to do so. It was agreed however, to make regulations to enable the community health councils to appoint their own staff, though it would not be written into the Bill. Mr. Blenkinsop again attempted to ensure that community health councils would not share staff, expenses or premises with the area health authorities, on the occasion of the Third Reading of the Bill, and he indicated that this was the view of the local authorities[2]. Sir Keith Joseph again rejected this amendment, although he accepted amendments to secure that the chairman of the community health council would be elected by its members, and to secure that no member of the community health council to be a member of the regional or area health authority[3]. Mr. Blenkinsop reported his activities and lack of success to the AMC by letter.[4]

The issue of co-terminous boundaries between local government and health authorities assumed great importance for local government from the time of the second Green

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[1] Parliamentary Debates, House of Commons, Official Report, Standing Committee G, 1972-3, volume 5 cc. 704-12, 15 May, 1973.

[2] 857 H.C. Deb. 5s., cols. 1422-5.

[3] Ibid.

[4] Municipal Review, Supplement, 1973, p. 219.

Paper onwards. Up until then, the Local Authority Associations had been concerned to advance the case for unification of the NHS within local government, so the question had not arisen. The second Green Paper suggested that although the Health Service was not to be administered by local government, the number and the area of the new health authorities would be co-incident with the new local government boundaries recommended by the Redcliffe-Maud Report. The AMC welcomed and supported the decision

> "that in general the number and areas of the new health authorities will be co-terminous with those of the new unitary and metropolitan district authorities. A decision on the number of health authorities will be determined by the final map of reformed local government and it is, in the Association's view, appropriate that this should be the case"[1].

Similarly, the CCA welcomed the decision that area health authorities should, in general, match local government areas and the acknowledgement of the inter-dependence of health, social and other local government services[2].

The Local Authority Social Services Act of 1970, which implemented the recommendations of the Seebohm Report, saw the General Purposes Committee of the AMC stress the matter further.

> "We have also invited the Secretary of State to re-assess the situation with regard to the re-organisation of the NHS and to develop alternative proposals in relation to the service to ensure that the areas of administration correspond with those for local government generally and with a view to bringing the service into an even closer relation with local government"[3].

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[1] Municipal Review, Supplement, 1970, pp. 160-61.

[2] Minutes of the Executive Council, March, 1970, p. 74.

[3] Municipal Review, Supplement, 1970, p. 180.

Similarly, on receiving the news from the DHSS that the NHS was to be unified outside local government, the Parliamentary and General Purposes Committee of the CCA immediately replied emphasising the importance of co-terminous boundaries between local government authorities and health authorities[1]. In its own comments on the Consultative Document, the AMC suggested that the meaning of the term "Districts" in relation to the Health Service structure was unclear, but that they should be co-terminous where possible with local authority districts, though this might be impractical in some cases because of hospital siting, and an aggregation of local authorities in these circumstances might be appropriate[2].

It was here that the problem arose in relation to co-terminous boundaries. The Consultative Document had fixed the main focus of collaboration at the area health authority level by providing for co-terminous boundaries with local government. Sir George Godber had wanted health authorities based on district hospitals, but the Local Authority Associations indicated that they could not build collaborative arrangements on this basis, hence the arrangement at area level and the existence of an otherwise superfluous tier in the NHS structure.[3] Subsequently, the Working Party on Collaboration looked at co-terminous arrangements at district level, where it was agreed that wherever possible NHS Districts should correspond to local

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1 Minutes of the Executive Council, 1970, p. 280.

2 Municipal Review, Supplement, 1971, pp. 154-6.

3 Information provided by Mr. T.A. Nelson in an interview.

authority district boundaries and social service 'areas'[1]. Local government thought highly of its achievement in this aspect of re-organisation and regarded co-terminous boundaries as a major break-through. One participant remarked, "We got co-terminosity except in London. There are no complaints from local authorities on co-terminosity. There are some from hospitals"[2]. Another said, "There are few complaints from our local authorities saying things don's work"[3].

Securing the greatest possible degree of collaboration between the health and social services was an objective which greatly exercised local government. The memorandum from the CCA to Mr. Robinson prior to the first Green Paper had stressed the need to promote effective relationships between medical practitioners and social services, and suggested that not only would this become increasingly important, but that the extent to which family doctors in particular would be able to develop the social and preventive aspects of their work would be likely to depend on the closeness of their working relationship with the staffs of local authorities[4]. Again, one of the principal objections raised by the CCA to the first Green Paper was that whilst it shared the view expressed in the Green Paper that there was a need to plan and operate the social work and medical services in close association with each other, it found it difficult to reconcile this view with the Minister's proposals. The growing emphasis on

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1 A report from the Working Party on Collaboration between the NHS and Local Government on its activities to the end of 1972 (HMSO 1973), paras. 2.17-2.21, pp. 12 - 13.

2 Mr. T.A. Nelson (CCA) in an interview.

3 Mr. C.J. Berry (AMC) in an interview.

4 Minutes of the Executive Council, 1968, pp. 234-9.

community care was bound to mean that there would be many cases with both social and medical needs. The setting up of completely separate administrative structures for the health and social services would jeopardise existing joint working arrangements, and could not be expected to promote the collaboration which the Seebohm Committee recommended between the proposed new social services department and the Medical Officer of Health and his team[1].

After the publication of the second Green Paper, the CCA were asked to comment on a confidential memorandum from the DHSS on collaboration between the NHS and local government. The Association pointed out that the deeper the consideration given to the administrative arrangements suggested for collaboration and co-ordination, the more incongruous the proposed structural division between health and local authority services seemed to become. The Association urged the DHSS to set up without delay, a multi-disciplinary Working Party, including representatives of the Association, so that the problems could be explored as fully as possible before the drafting of legislation reached an advanced stage. The following draft terms of reference were suggested;

> "In the context of the proposed re-organisation of the National Health Service and Local Government to consider:
>
> (a) the need and scope for collaboration and co-ordination between health, social, educational, housing and other local government services both from the point of view of patients and the public generally and in order to secure the most effective

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[1] Ibid., p. 268-271.

and efficient use of scarce resources of staff, buildings, vehicles and equipment, and

(b) the factors likely to impede or prevent effective collaboration and co-ordination, including the sufficiency of statutory enabling powers,

and to make recommendations"[1].

This idea was taken up by the Conservative Government and became an effective vehicle for local authority influence. At a meeting on 26th April, 1971 with Lord Aberdare, it was indicated that the Government now proposed to take the suggestion up, and the CCA was asked specifically for the terms of reference it had in mind[2]. At a subsequent meeting on the proposal, the matter proceeded very smoothly. As one participant put it, "This may have been to draw the teeth out of the opposition to the Bill"[3].

The Working Party divided into three sub-committees on school health, personal social services and environmental health, and subsequently three further sub-committees were established on finance, management services and Greater London. It was from the Working Party that the recommendation that Joint Consultative Committees should be established at AHA level came, and this was given statutory recognition[4]. These JCCs were to oversee the provision of appropriate services from both local government and NHS sides, and to compare and comment on the forward plans of the relevant services. The sub-committee on personal social

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1 Ibid., 1970, p. 133.

2 Minutes of the Executive Council, 1971, p.96.

3 Mr. T.A. Nelson (CCA) in an interview.

4 A report from the Working Party on Collaboration between the NHS and Local Government on its activities to the end of 1972, HMSO, 1973, para. 2.7, p.11.

services dealt with the transfer of medical social workers to local government which went ahead in spite of vigorous protests from the two medical consultant members of the sub-committee, although it was hedged around with numerous safeguards relating to levels of staffing and the continuing employment of the staff in the hospital situation[1]. The sub-committee on environmental health arranged for the provision of a 'proper officer' by the AHA for the control of infectious diseases and outbreaks of food poisoning, who would also act as adviser to the local authority on health matters. The provision of proper medical advice to the local authority had been the cause of some concern to the BMA who had feared that local government might re-incarnate the old medical officer of health type of appointment for this purpose[2]. The sub-committee on finance fairly readily agreed three main issues. First, the provider would pay for all professional services. Second, the user would pay for all other facilities. Third, the financing of JCCs would be equally divided[3].

The achievements of the Working Party on Collaboration were highly regarded in local government circles. One participant said,

> "if anything was achieved it was in the Working Party in relation to the machinery established. The people who served on the Working Party should be given credit. The stuff they produced seemed generally acceptable at the end of the day. There was no major thing that was not acceptable.

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1 Ibid., para. 5.21, p. 45, 5.36, p. 50, and paras. 5.39-5.40, p. 52.

2 Ibid., paras. 3.4 - 3.20, pp. 18 - 21.

3 A report from the Working Party on Collaboration between the NHS and Local Government on its activities from July, 1973 to April, 1974, paras. 3.31 - 3.34, p. 21.

> It has been implemented and is working. When Things work you don't hear about them. There have been few complaints from authorities saying things don't work"[1].

Another said,

> "We were well represented by able people. We didn't get an adverse response from any quarter. It was well chaired and well secretaried. Attendance was good and people made a constructive contribution"[2].

The final issue about which local government concerned itself was the position of the School Health Service. The Local Authority Associations viewed with concern the omission of any reference to the service in the first Green Paper. The AMC in its observations on the Green Paper therefore pointed to the importance of the link between the existing local authorities' health and education services which, the AMC indicated, was well described in the Ministry of Health's evidence to the RoyalCommission on Local Government.

> "with Education, the main link derives from the need for a close working relationship between the school health service and those services provided by the health department for children under school age"[3].

The CCA in its comments on the first Green Paper remarked:

> "The setting up of completely separate administrative structures for the health and social services would jeopardise existing joint working arrangements and would not be expected to promote the collaboration (paragraph 383). The school health service, which the Green Paper does not even mention but which is not readily divisible from either the Education or Health Services, is a case in point. If local health services were transferred to Area Boards leaving the school health service isolated there would be serious staffing difficulties. Alternatively,

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[1] Mr. C.J. Berry (AMC) in an interview.

[2] Mr. T.A. Nelson (CCA) in an interview.

[3] Municipal Review, Supplement, 1968, p. 309.

> if the school health service were to be merged in a unified health service separate from local government, local authority child guidance work, in particular, would be seriously impaired"[1].

The omission of reference to the school health service in the first Green Paper was repaired in the second by the proposal in the second that the school health service should be transferred to the NHS[2]. It was left unclear how this would be organised and it was simply suggested that it would be provided "by doctors, especially paediatricians". The Local Authority Associations regarded this as quite unrealistic, and felt that the importance and complexity of what was involved was not appreciated by the DHSS. It is not surprising, therefore, that at its meeting on 7th May, 1970, the Education Committee of the CCA expressed its concern about the special role of the school health service and about the need for preserving effective co-operation between educational and health interests[3].

When it became known in November, 1970, that the NHS was to be re-organised outside local government, the Local Authority Associations became actively concerned about the future of the school health service. As one participant put it, "We wrote papers and got support in the Cabinet".[4] As part of their joint approach to the subject, the AMC and the CCA, together with the Association of Education Committees, the Welsh Joint Education Committee and the Inner London Education Authority, agreed a joint

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1 Minutes of the Executive Council, 1968, p. 270.

2 Para. 32, p. 10.

3 Minutes of the Executive Council, 1970, p. 116.

4 Mr. T.A. Nelson (CCA) in an interview.

document to be used at a meeting with the Department of Education and Science on 14th January, 1971. This document indicated that the bodies concerned were not confident that the expectations relating to the future of the school health services as set out in paragraphs 32 and 33 of the second Green Paper would be realised. It stressed the need for the integration of the school health service into the education service as a whole, and that there was an urgent need for a study of the professional, administrative and financial factors involved. It urged that an attempt should be made to define and evaluate the existing and prospective functions of the school health service, and proposed that a study of the school health service should be made. It was argued that special consideration was needed to :

(a) determine policies by arranging for submission of agreed proposals to appropriate Government Departments for confirmation,

(b) resolve differences as to policies and priorities between area health authorities and local authorities,

(c) determine financial responsibility between local authorities and area health authorities,

(d) ensure acceptable performance of agreed policies, e.g. by the provision of suitable default arrangements,

(e) ensure adequate local authority involvement in matters of joint concern including appointments,

(f) encourage close working relationships.

Finally, the document indicated the willingness of local government to participate in such a study, although its position on the outcome was reserved, and it was also indicated that if the results of the study were unsatisfactory

local government might wish to reserve the right to appoint such staff as might be necessary to ensure an effective school health service. The importance of the contribution of the school health service to the education service was also emphasised, and the necessity to reverse any tendency for it to run down as a result of uncertainty was stressed[1].

At the meeting, the DES acknowledged the need for a joint study to consider how to ensure the continuance and development of the school health service, and asked for a paper to include the definition and evaluation of the existing and prospective functions of the school health service, and an outline of the local authority view on the problems facing the school health service after re-organisation and on the arrangements for its continuance and development as part of the re-organised NHS outside local government[2]. The outcome was a lengthy and powerful paper which pointed to the development of the school health service from dealing with malnutrition, infectious diseases and infestations to increased functions dealing with early detection of handicap, examination and screening of children throughout school life, investigation of school absences related to physical and emotional causes, immunisation, oversight of environmental hygiene and safety in schools and colleges, advice to local education authorities on the health and medical examination of teachers, dental inspection and treatment, provision of speech therapy and

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[1] Ibid., 1971, pp. 10-11.

[2] Ibid., 1971, p. 92.

physiotherapy, and liaison with colleagues concerned with the child in the pre-school years.

It was argued that "there is no prospect of these important needs being met outside the school health service whose personnel are the only ones with adequate training". It was pointed out that the service was now moving into the broader fields of prevention of ill-health in childhood and concern with mental and emotional problems. The potential importance of the service in the field of research into child health was emphasised and it was urged that the service could be extended to the Further Education and College of Education sectors. The differences between the school health service and clinical practice were outlined and it was argued that "There are therefore very cogent reasons why the school health service should continue as a specialised service but must retain close links with the medical services concerned with community preventive health. The school child cannot be considered as a separate entity from the pre-school child or the adolescent in employment".

The paper went on to argue that the scope of the school health service exceeded that of consultants and general practitioners, administratively and clinically, and that there was no prospect of their being able to provide the whole range of existing and prospective services comprising the school health service. Arrangements were therefore necessary to ensure that the services currently provided by the school health service were continued and developed, that good relationships with teachers were maintained, and that provision for identifying and providing

for new needs must be made.

It was concluded, therefore, that specific provision for the school health service must be made by the NHS re-organisation statute in such a way as to ensure an effective relationship between health and local education authorities be maintained and that the location and functions of medical administrators were closely defined.

> "It is not difficult to visualise a situation where, in allocating resources, separate administrations give priority to services which come indisputably within their respective provinces without making provision for grey areas. Potentially, the School Health Service is such an area. In the abstract, there may well be general agreement as to its value, but in practice, in the context of health authority administration, there will often be other priorities thought to be more pressing. And even if the Medical Officer of Health, Community Physician or medical is fully seized of the value of the service, it would be unrealistic to assume that his 'fellow consultants' will accept his assessment".

It was suggested that from the outset a joint approach to areas of common concern should be established between health and local authorities, where the services to be provided by the separate administrations were complementary. As a suggested basis for discussion, it was proposed that health and local authorities should be required to confer and prepare agreed proposals as to the development of their respective services in so far as they were of mutual concern, given that many of the objectives of both types of authority could not be achieved except in partnership. In the case of the School Health Service, the local authority would be dependent on the health authority. In other cases, for example social services for hospital patients, the health authority would be dependent on local authority. "Such

mutual dependence should give reasonable scope for give-and-take and should largely avoid the need for the reference of differences to the Secretary of State or the exercise of default powers". Similarly, complex and unproductive accounting procedures for costing and payment for services could be avoided. It was considered necessary, however, for local education authorities to have access to expert medical advice as of right on matters affecting the health, education and care of school children and students, and for the chief medical officer of an area health authority to have a statutory responsibility to report to and advise the appropriate education authority. Special arrangements would be necessary where the areas of the education and health authorities were not co-terminous[1].

The result of this pressure was that the support of both Mrs. Margaret Thatcher and Mr. Peter Walker was obtained in Cabinet, and Sir Keith Joseph was forced to recognise the importance of the issue and ensure that provision was made to deal adequately with it[2]. Support was also obtained from the Press, notably from John Izbicki in the Daily Telegraph[3], as a result of a well-attended press conference held in a public house off Fleet Street.

In the event, the school health service was one of the matters referred to the Working Party on Collaboration, with fairly satisfactory results from the local government point of view. A statutory duty was to be placed upon the NHS to provide medical and dental inspection and treatment

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1 Ibid., pp. 92-6.
2 Information provided by Mr. T.A. Nelson in an interview.
3 J. Izbicki, Daily Telegraph, 27 March, 1971.

to school children, and the area health authority was to be responsible for the appointment of a senior doctor, dentist and nurse to give 'independent' advice to the local authority. The appointment was to be made with the agreement of the local education authority whose representative would be present. The sub-committee of the Working Party which dealt with the issue was initially faced with the question of whether to leave the school health service with local government or to integrate it into the NHS, and the latter course was chosen in spite of the dissent of Sir William Alexander of the Association of Education Committees, Mr. D. Andrew Davies of the Welsh Joint Education Committee and Mr. G. Turner, Principal School Dental Officer of the City of York. The dissenters questioned whether the NHS would accord the school health service proper priority and whether differences of opinion voiced in JCCs would be satisfactorily resolved. They also wanted the continuance of concurrent powers to provide the service for both local government and the NHS[1].

In spite of the dissent expressed by these three representatives from local government, the Local Authority Associations found little difficulty in accepting the proposals, which rejected the notions of giving local education authorities powers to appoint medical staff to supplement general health provision after consultation with the area health authority, and of giving full powers to local education authorities to appoint staff for medical

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[1] A report from the Working Party on Collaboration between the NHS and Local Government on its activities to the end of 1972, HMSO, 1973, paras. 6.19-6.22, pp. 66-7, and paras. 6.52-6.55, pp. 74-5.

and dental inspections in schools. It was agreed that the resolution of problems by co-operation was more helpful than the views about the retention of powers by local education authorities as expressed in the note of dissent. The proposals were accepted subject to :

(1) the senior doctor with school health responsibilities having the status and powers to ensure efficient administrative arrangements

(2) the administrative arrangements extending down to individual schools in order to preserve existing relationships

(3) legislation proving for the flexibility envisaged in local arrangements

(4) financial arrangements based on the general principle of reciprocal arrangements without recoupment

(5) satisfactory resolution of the problems of local education authorities with school health services provided by more than one area health authority[1].

It is clear that the decisive reasons for the arrangements agreed were that the school health service would have been placed in an anomolous position if it had been separated from the NHS and that there was a need to provide a proper career structure in clinical public health provision which could be more easily done within the NHS. The Hunter Working Party on Medical Administrators[2] stressed the importance of clarifying the role and location of such non-administrative local authority doctors within the re-organised NHS.

In spite of their success in obtaining special attention for the school health service, some local

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[1] County Councils' Association, Minutes of the Executive Council, 1972, pp. 218-9.

[2] Report of the Working Party on Medical Administrators, (Hunter, Ch.), 1972, paras. 53-55, pp. 22-23.

education authorities have remained disquieted since they remain responsible for the identification and placement of handicapped pupils and for providing special education. However, as Thomas and Stoten have put it,

> "In practice the medical, nursing and other health care expertise exercised here is unlikely to differ significantly after re-organisation"[1].

Local Government overall did not come out of the re-organisation of the NHS with a great deal to show for its efforts. Its claims to take over the NHS were treated with ambivalence by the officers of the Local Authority Associations, who were well aware of the difficulties involved. As one observer put it, "Although they argued their masters' case like good civil servants, it never sounded convincing"[2]. In spite of some success with the Working Party on Collaboration, particularly in relation to the school health service, in securing representation on the area health authorities and securing co-terminosity of health authority and local authority boundaries, in the main local government had to be content with the knowledge that both major political parties had taken the point in relation to the logic of ultimately unifying the NHS within local government. As one participant somewhat glumly put it,

> "I don't think they (local government) were ever contemplated in Whitehall. The key was medical officers of health. Once Godber got them to agree they had no future in local government no-one else ever cared very much. From then on we were not very effective in spite of great effort. We were most effective in getting Robinson's ambulance proposals shelved. He had hoped this would be a stepping stone"[3].

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[1] N. Thomas and B. Stoten, The NHS and Local Government: Co-operation or Conflict? in K. Jones, The Year Book of Social Policy in Britain, 1973, Routledge and Kegan Paul, London, 1974, p.61.

[2] Lady Serota in an interview.

[3] Mr. T.A. Nelson in an interview.

CHAPTER VII

The Role of the Pressure Groups: The British Medical Association

(a) Introduction

In order to understand the position of the BMA in relation to the re-organisation of the NHS, and the difficulties and problems it encountered in arriving at its views, it is necessary to have some appreciation of the constitutional structure and the political realities of the Association. Its constitution is complex, extensive, and in some areas nebulous, and does not necessarily reflect the political realities.

The governing body of the Association is formally the Representative Body which meets annually, and it consists mostly of representatives of the local divisions and branches into which the BMA is divided. The meeting hears reports from officers of the Association and debates resolutions and amendments submitted by its constituencies, and serves as a sounding-board of professional opinion. Effectively, however, its power is constrained by the provision that decisions of the Annual Representative Meeting will rank as 'decisions of the Association' only if carried by a majority of two-thirds, which means that such decisions are rarely carried against the wishes of the Association's leaders, and then with avenues of escape left open. Nevertheless, the Annual Representative Meeting has recently been more restive about its decisions being disregarded by the Association's leaders and officials, and demands have been made that the leaders should be more accountable to the Representative Body. Although as a result, the leaders

have tended to be more responsive, nevertheless they take care that decisions which might prejudice their position with the DHSS are not pressed with any vigour. Special Representative Meetings may be called by the Council for matters of great magnitude and pressing importance on which the views of the Representative Body are considered essential.

The executive body is the Council which manages the affairs of the Association. This is probably the seat of true authority, but not necessarily the effective location of real power, as it is too large a body, and meets too infrequently to manage effectively the complex affairs of such an Association. Nevertheless, the Council effectively dominates the Annual Representative Meeting, and its Chairman is the most powerful political figure in the BMA. The names of the most important Council members are to be found on the lists of members of the Association's multifarious committees, and the Chairman is an ex-officio member of all standing committees. The same members tend to play an important role at the Annual Representative Meeting, on the standing committees, and in high-level negotiations.

The Secretariat of the Association is also of great importance, and consists of a Secretary, Deputy Secretary and six Assistant Secretaries, and many of the day to day discussions with the DHSS are carried on by these officials, who have close contact with their opposite numbers in the Civil Service. Most deputations to the DHSS tend to consist of the Secretary or Deputy Secretary, Chairman of Council,

and the Chairmen of the three most important committees.

These three most important committees are the General Medical Services Committee, the Central Committee for Hospital Medical Services, and the Public Health Committee. They represent one of the more nebulous areas of the BMA's constitution, but are of crucial importance in formulating the policies of the BMA, and as such, their different positions in relation to the re-organisation of the NHS will be separately considered below. The General Medical Services Committee and its sub-committees are formally considered to be 'autonomous bodies' within the BMA, and in practice it has a trade union function in representing all general practitioners serving under the NHS, not merely those who belong to the BMA. In this capacity, it is recognised by the DHSS, and it is constitutionally responsible to the Conference of Local Medical Committees, which does not seem to have any particular importance. The formal association of the GMSC with the BMA is unclear, and probably from the BMA's point of view is usefully unclear in that it enables the Association to remain formally aloof from anything approaching trade union activities, and to gloss over the fact that whilst the Association does not represent the entire medical profession, the GMSC does speak for all general practitioners. Nevertheless, the GMSC reports to the BMA Council, which treats it as one of its standing committees, although this committee seems to be quite capable of making distinct and separate representations to the DHSS when it chooses to do so.

The concept of autonomy is also adhered to strongly in the case of the Central Committee for Hospital Medical Services. This probably arises because the consultant sector of the medical profession is represented by a variety of powerful bodies outside of the BMA. Thus, in negotiations with the DHSS, the CCHMS merely sends representatives along with other bodies to the Joint Consultants' Committee which is recognised by the DHSS for the purposes of negotiation with hospital medical staffs. This does mean that the BMA speaks with less authority on matters touching consultants, who have their own prestigious bodies with which the DHSS also deals. It was this division which was effectively exploited by Aneurin Bevan in the establishment of the NHS. The CCHMS also seems to be in a position to make direct representations to the DHSS if it chooses.

Finally, there is the Public Health Committee, which "undertakes medico-political activities for the Society of Medical Officers of Health". This committee has severe normative inhibitions against both trade union and political activities. This is probably the weakest of the three committees, partly by virtue of the general disregard of the local authority public health service displayed by the rest of the medical profession and partly because out of 22 members, it is possible that only four might be directly representative of the public health service, although other such members may be elected by the Representative Body, Council, or may be co-opted. This may be contrasted with 33 members out of 56 on the GMSC who are likely to have a direct interest in general practice, and 53 members out of

67 on the CCHMS who are likely to have a direct interest in consultant concerns. Thus, one of the sectors most immediately affected by the re-organisation of local authority social services and the NHS was perhaps in the weakest position at the BMA.

To complete this picture of the BMA structure, it is perhaps desirable to mention the Conference of Honorary Secretaries of Divisions and Branches, which does not normally seem to have much significance, although it seems occasionally to be used as a political device, e.g. for gaining time[1].

This description may serve to indicate the difficulties under which the BMA laboured in endeavouring to arrive at a coherent view to present to the DHSS on such a vast subject as the re-organisation of the NHS. The deep-rooted split between the general practitioners and the specialists, and the ability of the latter to get their point of view authoritatively put by other bodies is one aspect of this. It meant that any re-organisation of the NHS was likely to be viewed from different perspectives by the GMSC and the CCHMS, and the Council would be faced with the task of reconciling these differences. A similar difference can be traced between those doctors working in the public health sector, and those engaged in their own practices, which presented further difficulties for the Council. In addition, there exist all the tensions which

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[1] The material for this account of the constitutional and political structure of the BMA has been drawn from H.H. Eckstein, Pressure Group Politics, Allen and Unwin, London, 1960, and chapter II in particular contains a valuable account of the setting of BMA politics, and also the British Medical Journal, Supplement, and the BMA, Year Book, 1970.

would be associated with such a large and diffuse organisation. These tensions would include those between old and young, the latter being provided for in the Young Practitioners' Sub-committee of the GMSC. Young Specialists also have their own Hospital Junior Staffs Group of the BMA. The Association thus faces real problems in preserving a facade of unity to the DHSS, and also has to cope with the knowledge that it does not enjoy the support of the whole medical profession, not all of whom are members, and that many of those who are members are apathetic towards its activities. This means that in any last resort situation, its leaders cannot necessarily count on as wide a measure of support for their proposals as they might wish or as they might try to suggest to others, and probably would not want to put the matter to the test. Apart from this constraint however, the existence of other more peripheral doctors' organisations must also be noted, as their views would also at least reach the DHSS. The Medical Practitioners' Union and the Socialist Medical Association are good examples. The existence of an extremely widely-read and influential independent medical journal, the Lancet, must also be noted, as the views expressed there reach a wide audience, and by no means always coincide with those expressed by the BMA. Some of the issues taken up by these other medical institutions will be outlined below. However, in order to examine the role of the BMA, the formulation of the views of the three important committees will first of all be investigated separately, and then the attempts of the Council to reconcile them and put forward a coherent view

as the re-organisation of the NHS progressed, will be discussed.

(b) <u>The General Medical Services Committee</u>

The General Medical Services Committee found itself confronted by NHS re-organisation first on 11th July, 1968 when it received the report of the working party set up by the Council on NHS Administration, aimed at bringing the Porritt Report up to date and studying other relevant reports concerned with the administrative structure. It gave rise to immediate controversy in that the working party did not wish the report to be published before the Green Paper as it intended to produce guidelines for the Association's representatives "allowing them a degree of flexibility in their discussions with the Ministry". It was therefore proposed to postpone discussion of this document until the September meeting of the committee. However, not all members of the committee were happy about this on the grounds that the Association should have its ideas crystallised by the time the Green Paper was published, and that the committee should be prepared to give guidance to local medical committees.

There were also indications that the general practitioners were beginning to take up defensive positions. Dr. H. S. Howie Wood expressed the view that the rivalries of the tripartite system could easily be overcome by co-operation. He wanted to ask the proponents of the report

> "whether under the scheme general practitioners in the Health Service would have the same control over their affairs and the same contacts with their patients and with the official machinery of the Health Service as they had in the existing system of local medical committees, executive

> councils, and local contacts with the other two branches of the service. We must have some counterblast ready, because if the Green Paper sets out what we believe it will, it will sweep the general practitioner into a general mix-up in which he will occupy a quite subordinate place compared with the place which he occupies now in the administration of his own affairs in the Health Service".

Dr. R.H.L. Ridge pointed out that the report suggested that a pilot scheme would "impose an intolerable delay on the introduction of an administrative reform which, in broad terms, is now widely agreed as essential". He suggested that before the committee was in a position to say that this type of administrative reform was "now widely agreed as essential" it must put the report before the Annual Conference of Representatives of Local Medical Committees. Dr. D.L. Williams, who was a member of the Welsh Sub-committee on Area Health Boards, compared the report with that of the sub-committee, and found three points of disagreement. He argued that a two-tier system was more suitable for general practice, and it was wrong to throw this out in favour of a one-tier system, that the composition of area health authorities should include doctors as one-half of their membership, whereas the report suggested eight out of 27, and that the lay members should be elected where the report suggested Ministerial appointments[1]. Eventually, the discussion of the report was postponed to the September meeting.

At the September meeting, the committee considered the Seebohm Report, the Green Paper and the report of the BMA working party on the re-organisation of the NHS, bearing

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[1] British Medical Journal, Supplement, 1968, p.90.

in mind that the reports of the Royal Commission on Local Government and the Royal Commission on Medical Education were still awaited. Immediately, alarm and concern were expressed at the implications of these documents for "the quintessence of general practice". Dr. C.J.Wells expressed alarm at the concept of a team providing care for urban populations rather than a personal doctor, whilst Dr. B.D. Morgan Williams thought that Seebohm was written with a disregard for confidentiality, and ignored the personal relationship between doctor and patient and Dr. D.L. Williams also attacked Seebohm on this point and thought it would lead to a breakdown of the relationship. Dr. C.D.L. Lycett declared the policy of the BMA to be to bring the services of welfare departments together with the health departments of local authorities under the Medical Officer of Health, but this was not what Seebohm was suggesting. He saw the Seebohm Report as cutting out the general practitioner and medical officer of health to a large extent as it regarded confidentiality as anachronistic and wanted to see consultants working directly with social workers. Dr. J. McA. Williams saw in Seebohm "appalling visions of the future", and suggested the family doctor must have four safeguards, namely, independence at all costs; leadership of the team; a powerful say in the re-organisation of the NHS; and the retention of his position as family doctor. Other members of the committee saw related dangers. Dr. M.A. Weller thought that the general practitioner should be at the centre of everything, but that the Green Paper's unified health board would give the hospital service over-emphasis. Dr. B.L. Alexander saw in

the Green Paper the disappearance of the general practitioner's independence and the evolution of the detested salaried service. Membership of the proposed area health authorities also caused concern. Dr. J.H. Marks pointed out that the BMA report proposed eight members of the medical profession out of a total membership of 27 whereas the Green Paper spoke of some members "with broad professional knowledge of medical and related services .... though it would not be desirable for them to be nominated to represent special interests". Dr. J.R. Caldwell expressed concern for the position of the local medical committees, which

> "over the last 20 years have had a proper organisation, and, more important had commanded cash. In the last 20 years, local medical committees had been able to threaten the Minister. If the Minister abolished them who was going to fight the battles for the hospital doctors, the local health authority doctors, and the service doctors? All had in the past depended on the threats of industrial action proposed by general practitioners financed by their defence trust".

However, some voices were mildly raised on the other side. Dr. E. Townsend reminded the committee that it was the profession who had first asked for area health boards. The Green Paper was an opportunity to be grasped, although this was not to say he accepted it. He pointed out that no decisions would be taken until representatives of those concerned had been consulted, and general practitioners had the solution in their own hands, as if the administrative structure proved unworkable, the doctors could get out. He suggested there were three points where the administration needed to be changed. First, much more

co-ordination of services was necessary. Second, the efficiency of services could be greatly increased without extra money, though more money would be needed. Third, there should be maximum participation not only of the profession but of patients, and local autonomy had to be considered. He also suggested that the Younghusband Report indicated that social workers today were highly trained, hence Seebohm's separate organisation. Personally, he did not agree with it, but it had to be taken seriously. Dr. J.L. McCallum suggested that the division of the service into three administrative organisations had obstructed the provision of the best services.

> "Surely the fact that the Ministry at last have come round means that this is our chance. The general practitioner will have the chance to control what is going on in the Service. We have to be the leaders not only of the teams but the leaders of the area health boards, because we are the only people who understand what is going on"[1].

In the above discussion, the basic positions which the general practitioners were determined to defend emerge, along with some of their ambitions and divisions. The problem was referred to a working party by the committee, and it duly presented its report on 21st November, 1968. The report set out five principles, and two major recommendations. The principles were :

(1) the objective of any change must be improvement of the service for the community;

(2) the independent contractor status of the family doctor, necessarily implying freedom of choice between patient and doctor, must be maintained;

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[1] Ibid., 1968, pp. 115-8.

(3) whatever the circumstances, absolute confidentiality both between patient and doctor and between doctor and doctor must be maintained;

(4) clinical independence of the family doctor must not be impaired; and

(5) the relationship between the Government and the medical profession should be one of genuine partnership, providing for agreement in planning and participation in administration.

The recommendations were:

(1) area boards of the size proposed should be charged only with planning and research duties in the main; and

(2) that within each area smaller units (district boards) be charged with management[1].

This report was accepted as a basis for a document, with amendments emphasising opposition to a salaried service and protecting both independent contractor status and the right to practise wholly or partially outside the NHS. In the discussion, Dr. B. Holden astutely put his finger on a significant point when he said he thought that the authors of the Green Paper had pre-knowledge of Seebohm, and probably the Redcliffe-Maud, reports. "The profession was in grave danger it would be too late in the field". There was some disagreement as to whether local medical committees took the view that unification was desirable.
Dr. D.L. Williams thought that local medical committees simply thought this was not the way to do it, whereas Dr.D.R. Cook felt there was evidence that the existing tripartite structure presented no insurmountable difficulties in the administration of the Service and should be retained. "It was pretty obvious that local medical committees did not wish to see unified administra-

[1] Ibid., 1968, pp. 49-52.

tion - since that meant that that part of it concerned with general practice must inevitably take a subordinate part". Dislike was expressed for the phrase "management of manpower", and there was some tendency to confuse this with direction of doctors. There was also some disagreement as to whether a bi-partite structure, putting local health authority services under executive councils and leaving the hospital service unaffected, would be feasible. However, this raised the bogy of executive council services being put under local government, and the committee agreed it did not want general medical services to be administered by local authorities. Indeed, some preference emerged for retaining executive councils. As Dr.G.R.Outwin pointed out, "the big problem is maintaining independence" - if general practitioners lost the independence of contract a relatively independent executive council afforded them now, what hope would there be of asserting their independent status "with a board serving the interests of hospitals, general medical services, and the lot?". Finally, the committee agreed to adopt the following cautious and defensive proposals from the working party report.

> "Family doctors would be the last to maintain that there is no room for improvement in the Health Service and we make the following two major recommendations:
>
> (1) that area boards of the size proposed be charged in the main only with evaluation and planning; and
>
> (2) that within each area existing tripartite arrangements would continue with acknowledgement of the need for increasing integration of local authority services with both

hospital and general medical services"[1].

In his report to the Council on the 18th December, 1968, the Chairman of the GMSC, Dr. J.C. Cameron stated that there would be a Conference of Representatives of Local Medical Committees on 22nd January, and that any decisions reached by the Conference would undoubtedly have an effect on the report that the GMSC ultimately submitted to the Representative Body. He pointed out that neither the Conference nor the GMSC had so far accepted the thesis that unification even on the lines proposed by the Porritt Committee was acceptable. The GMSC took the view that an effort should be made to increase the trend towards functional integration before undertaking a commitment to administrative change. One of the main anxieties felt by general practitioners about the Green Paper proposals was that these would put in peril their special independent contractor status. A situation might arise in which advantages might be given in the short-term to doctors who were prepared to work on a salaried contract[2].

The Special Conference of Representatives of Local Medical Committees duly met on 22nd January, and endorsed the recommendations of the GMSC, although it felt some concern lest general practitioners should be seen to be closing the door to administrative change, when many felt that some changes might be highly desirable. Consequently, it amended the conclusion of the committee "that the

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[1] Ibid., p. 52.

[2] Ibid., 1969, pp. 3-4.

existing tripartite structure should be retained" by adding "until a new structure has been agreed" and subsequently the GMSC agreed this amendment unanimously. The detailed proposals of the Green Paper were rejected as undesirable as a basis for reform of the NHS, but the Conference favoured area boards being established charged in the main with the evaluation of services and planning, but with no executive authority. An amendment stating that a unified administration of the NHS was desirable was defeated by 98 votes to 72. The mover made it clear he was not asking for approval for unification as set out in the Green Paper but simply for the general principle of unification. The fear was expressed by many speakers throughout the meeting that under a unified administrative structure general practitioners would be in danger of losing their status as independent contractors - a status which it was believed the existing executive council set up protected. During the debate on unification Dr. J.H. Marks, a member of the GMSC, pointed out that last year, the BMA working party on NHS Administration, including leaders of the GMSC, had pointed to the tripartite division as inefficient, wasteful of manpower, etc., and this had been amply demonstrated by Porritt, and "nothing which has happened since 1958 persuades the working party that this view was exaggerated". Dr. Marks remarked, "A few days later the Green Paper had been published, and in the panic that followed all that sound reasoning was forgotten"[1].

The Annual Conference of Representatives of Local

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[1] Ibid., 1969, pp. 27-47.

Medical Committees in June, 1969, moved further in the direction of change. It approved a motion supporting unification of the tripartite system, and felt that this would improve the status of general practice as a specialty and give general practitioners a say in the development and deployment of services which the existing structure did not. However, almost by way of contradiction, the Conference also carried a motion that in any re-organisation, the executive council structure should be retained, indicative no doubt of the ambivalence felt on the subject of re-organisation. Conference also attempted to ensure that no deals were arrived at behind its back by instructing the GMSC not to agree any proposals contained in a new Green Paper without prior consultation with the local medical committees, and the chairman said there must be a special conference to consider any fresh proposals[1].

The second Green Paper saw difficulties arise between the GMSC and the CCHMS, and the latter committee sent its comments on the Green Paper to the GMSC, which had to consider whether to circularise these to a Special Conference of Representatives of Local Medical Committees to be held on 5th May. It was pointed out by Dr. G.R. Outwin that a special conference had rejected unification as presented in the first Green Paper, as it could not see how the general medical services could be fitted into the hospital service without detriment to the former. The second Green Paper was more favourable from the point of view of the general medical services, and the position of the general

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[1] Ibid., 1969, p. 162.

practitioner would be virtually unchanged. For almost the same reason, consultants were unable to accept the new Green Paper. Dr. Outwin felt that the GMSC should give this slant to its recommendations to Conference, and that the Chairman might put this across in his opening remarks. Dr. I.M. Jones took the view that a decision had to be taken for or against unification, and that the CCHMS document, with its desire to maintain the regional board structure was a plea for the perpetuation of everything that had existed since 1948, a great deal of which was contrary to the best interests of doctors and of the community[1].

One decisive factor in causing the GMSC to take a more favourable view of the second Green Paper was that the Chairman, Dr. J.C. Cameron, pointed out that there was a large measure of agreement between the political parties, and he had attended a meeting where the Secretary of State and his Conservative shadow had said that once the White Paper was issued it would have the support of Government and Opposition. He believed that consultations had taken place, and that bargains had been struck between departments, and between central and local interests. Already the first piece had been moved across the board, as the Local Authority Social Services Bill had reached the House of Lords[2].

The GMSC thought, therefore, that the second Green Paper, for all its imperfections, was a basis for negotiation. A welcome was given to the increased number of area

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[1] Ibid., 1970, pp. 98-9.

[2] Ibid., 1970, p. 119.

authorities (90 as opposed to 50), which was seen as more suitable to general medical services. The direct participation offered to the community and the profession (albeit insufficient) was a welcome departure from 100% Ministerial appointments, as was the recognition by means of statutory committees of the need for special arrangements for the independent contractor services. It was pointed out that public health doctors were not displeased at the prospect of joining other branches of the profession, though they were worried by the Seebohm aspects of the proposals. Hospital staff, however, had misgivings about the disappearance of the regional boards and boards of governors and their replacement by regional health councils of a fundamentally advisory character. The committee reaffirmed the principles of general practice as independent contractor status, freedom of choice, confidentiality and clinical freedom. The implementation of Seebohm and the divorce of health and welfare was deplored, as was the degree of central control implied. It was agreed that both the confidentiality of records and the child guidance service should be under medical control, in view of the Local Authority Social Services Bill. The area health authorities should have as half of their total membership elected representatives of the professions, and one-third of the total membership should be representatives of the medical profession and one-sixth elected representatives of general practitioners. At a subsequent meeting on 21st May, the committee wished it to be made clear to the Secretary of

State that in any new administrative structure general practitioners would insist on being in contract with a statutory body of the area health authority which would have direct access to the central Health Department[1].

With the arrival of the Conservative's Consultative Document, the GMSC again found it necessary to reaffirm its essential position. At its meeting on 10th June, 1971, it stipulated independent contractor status, freedom of choice for patients and doctors, complete confidentiality, full clinical independence, no administrative control of the doctor outside the terms of his contract, planning of general practitioner services by consent, no direction of medical manpower other than through the existing powers of the Medical Practices Committee, and no variation of contracts and terms of service save with the consent of the profession. It was also determined that the GMSC must have power to continue to negotiate directly with the Secretary of State, and be consulted by the Secretary of State and his officers on all matters to do with general practice in the NHS. The proposals to eliminate elected professional membership of health authorities would be strongly opposed, and measures taken to ensure that strong effective medical advisory committees would be elected at all levels with a statutory right to be consulted by the area health authority and regional health authority, and that these committees would elect their chairmen, and that chairmen or their representatives would have a statutory right to attend all meetings of their respective authorities, and that planning and manpower committees of all health authorities would

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[1] Ibid., 1970, pp. 190-3.

include members from professional committees. It was also determined that committees for family practitioners' services must be established by statute to be directly responsible for securing the provision of general practitioner services, and stand in the same relationship to independent contractor status and local professional committees as executive councils did, with power to appoint their staff, and to have access to arbitration by an independent body in the event of a dispute with the health authority. Each health authority should be advised by local professional committees in the same way as executive councils, and the administration of family practitioner contracts was in no way to be subservient to area health authorities, whilst local medical committees were to continue to be established, and to be elected and to function as at present, and should elect the general practitioner members to the statutory medical advisory committees of the area and regional health authorities[1].

The committee in the event secured practically all its aims. At a meeting on 18th November, 1971, the Chairman was able to tell the committee that at a meeting with representatives of the BMA, the Secretary of State had given an assurance that there would be no change in the independent contractor status, and that the GMSC would continue to have direct access to the Secretary of State and the Department. Only the position of local medical committees remained in doubt. Subsequently in February, 1972,

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[1] Ibid., 1971, p. 138.

the committee expressed concern that the Management Study group were undertaking field trials without the consultations promised to the BMA[1]. This dispute was to rumble on between the Department and the BMA for some months, and partly no doubt to reassure the doctors, Sir Keith Joseph visited the GMSC on 22nd June, and reassured them that in the White Paper they would find all the sanctities of the general practitioner were intact[2]. Finally, at the meeting of the Committee on 16th January, 1973, Dr. Cameron was able to say that the whole of the routine monthly meeting with the Department had been devoted to discussing points in the NHS Re-organisation Bill to ensure the greatest possible measure of status and power for the family practitioner committees which would succeed executive councils, and the implementation of all the promises given concerning the future powers and status of local medical committees under the new regime. The general practitioners had been given, in effect, virtually everying they had asked for[3].

(c) The Central Committee for Hospital Medical Services.

The Central Committee for Hospital Medical Services set up a working party to consider the first Green Paper, and received its report on 10th October, 1968. The report indicated that the hospital service might have most to lose from dismantling of the present structure because of the distinctive features of the hospital service which needed larger regions than executive councils or local authorities, involved capital expenditure on a vast scale, and involved

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1 Ibid., 1972, pp. 55-6.
2 Ibid., 1972, p. 31.
3 Ibid., 1973, p. 23.

more complex medical techniques. There was a need therefore, to carefully examine any proposal for fusion in the light of these. The working party knew that the BMA favoured the Area Health Boards of Porritt, as against the tripartite system, and acknowledged that this was probably the pattern for the future.

The working party suggested therefore that the existing structure should not be over-hastily dismantled merely in the interests of conformity. The correct approach was by way of carefully evaluated pilot schemes. It feared the effect on hospital administration of reducing the structure from three tiers to two tiers would be to strengthen government control by civil servants at the centre. It welcomed the emphasis given to teaching hospitals in the Green Paper but saw a real risk in placing them under the new area authorities with special arrangements, as teaching and research might be subordinated to the pressing service needs in hospitals. The working party was against any direct fusion of local authority and health board areas, as health would then have to compete with other local authority services for finance and would be subject to the pressure of local politics. It felt that there was a risk of falling between two stools on the size of the areas, as they might be too large and remote for successful day to day management, and too small for planning. There was also the risk that the medical point of view might be submerged if boards had to include the hospital service, public health services, and general practice, and if only "some" of the members were to be medical. It

affirmed that the chief official of the area board should be medically qualified. It was also argued that re-organisation would afford the chance of looking at the finance of the service, and particularly the system whereby surpluses had to be returned to the government at the end of two years, which was not conducive to good planning[1].

The discussion on the report revealed considerable hostility to the Green Paper proposals. Dr. Owen Williams felt there was a danger that doctors would become managers not directors "in our own concerns". He urged the committee to view the proposals "with the utmost suspicion". Dr. Skene said the "whole object seemed to be malevolent" in relation to clinical teaching, postgraduate medical education, specialist services and research. Whitehall co-ordination and direction of the activities of the profession seemed possible. The Chief Administrative Officer of the area was likely to be lay, with the Chief Medical Officer as his advisor with a minimum of control. There was a need for the strongest representations to be made. Dr. H.A. Kidd argued that the proposals should go to the Hospital Medical Staffs Conference in December. "Getting rid of regional boards might give the Minister more power in allocation of private patient beds". Mr.A. Grabham said that under the Green Paper the Minister was trying to integrate the three services and to remove doctors completely from management committees and boards, and this was wholly unacceptable. The matter required thrashing out in detail, but time was running out and the

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[1] Ibid., 1968, pp. 13-15.

committee should state clearly that it opposed the proposals as they were at present. Mr. H.M. Bennett urged the committee to say to the Minister that it was opposed to the abolition of local representation on administrative bodies, as it provided an admirable reflection of local opinion. "It did no harm to have the lay consumer's viewpoint expressed from time to time". It was agreed that a revised paper should be produced in the light of the discussion, and forwarded to regional committees for hospital medical services[1].

On 18th December, 1968, Dr. M. Mayon-White, Deputy Chairman of the CCHMS told the Council that the committee was unable to accept the concept of area health boards proposed in the Green Paper, as they were not in the best interests of the hospital service.

> "A review of the position was necessary, and indeed, overdue, but the first step must be to experiment with integration within the existing structure. It was not that the committee did not favour integration, but that it wanted to see it begin at ground level".

It did not approve of the methods proposed for appointing board members. Vast numbers of lay people had given devoted service to the management of hospitals and had represented the patients more closely than the committee could see happening if the Minister's proposals were implemented. The committee was opposed to boards being administered by local government and feared that a large number of area boards might lead to the needs of teaching and research being subordinated to the day to day needs of hospitals[2].

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[1] Ibid., 1968, p.15.

[2] Ibid., 1969, pp. 3-4.

On 19th June, 1969, the Chairman reported to the CCHMS that the Secretary of State was working towards the idea of a two-tier system of district committees and regional authorities. It was agreed to press for hospital sub-committees to deal with day to day hospital affairs, and for a substantial representation of the medical profession in the administrative structure at both area board and district committee levels. The committee was opposed to the idea that half the members of administrative bodies should be local authority representatives, but it wished to see that the many voluntary bodies represented in the past continued to be represented[1]. At the meeting on 4th September, 1969, the Chairman reported that the Secretary of State had come out in favour of a two-tier peripheral structure, which accorded with the original view of the CCHMS. The Secretary of State was hoping before the year to produce a revised Green Paper "with elements of White in it"[2].

On 19th March, 1970, the committee considered a report from its working party on the future structure of the NHS. The Chairman expressed the fear that the second Green Paper would mean increased central control. Mr. H.H. Langston suggested that the dismantling of regional health boards and giving their functions to four different bodies was revolutionary. The general practitioner was left isolated. What was wanted was regional authorities linking six or seven Maud unitary authorities, and a two-tier executive structure which did not increase central control. Most

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[1] Ibid., 1969, p. 5.

[2] Ibid., 1969, p. 111.

concern was expressed about the need for adequate representation on area authorities. Mr. B.L. Howe for Hospital Dentists wanted 50% of the representation on committees to be representative of the major health professions. Mr. J.S. Elkington wanted area authorities to have 25% Health Department representatives, 25% local government representatives, 25% health profession representatives from the hospital service, and 25% representatives of the professions concerned with domiciliary practice. The committee agreed that at least one-third of area and regional authorities should be doctors in active practice. It was proposed that the committee reject the Green Paper, as there was nothing that would serve as a basis for discussion by the Council's Co-ordinating Committee. The resolutions of the Special Representative Meeting of 1969 constituted a basis for a discussion on the principles of re-organisation. In the event, it was agreed that the Green Paper failed to achieve the broad objective of integrating and unifying the NHS. The committee favoured unification, but executive control should be based on regional health authorities, each containing a medical school, ideally serving a population of two to three millions, with area health authorities as a second tier with executive powers to integrate hospital, local authority and general medical services, based on the areas of the main district hospitals. There should be statutory medical advisory machinery at area authority level. The appointment of medical staffs of registrar level and above should rest with the regional authority whatever administrative structure might be

established. For an area containing a medical school, representatives of the medical and dental interests of universities should be appointed as additional representatives to serve on all relevant committees[1].

The Conservative's Consultative Document when it appeared was badly received by the CCHMS. The Chairman pointed to the danger in the document, which suggested that broad lines of policy would be laid down in legislation, and the details filled in by special working parties, expert opinions and regulations. "We want to see the fundamentals now because it by no means follows that we can obtain what we want later". The management orientation of the document was disliked. Mr. R. Myles Gibson criticised its "obsession with management", and Mr. T.M. Hennebry said "Doctors were the management in the Health Service, the managers were at the bedside and should remain there". Mr. A.H. Grabham suggested that the document was about change rather than integration. General practitioners were to some extent being excluded, and large areas of the social services were to be separate, whilst to some extent teaching hospitals were being isolated from integration. "What remained were management changes in the regional hospital and some local authority services"[2].

Finance was another issue which caused alarm. Dr. F.W. Wright said that teaching hospital staff were worried they would find themselves at the bottom rung of a three-tier structure with no direct access to the Minister.

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[1] Ibid., 1970, pp. 13-14.

[2] Ibid., 1971, pp. 25-7.

Two representatives at regional level were not enough. The Chairman indicated that it was likely that a sum of money would go to the regional health authority which would decide how much would go to the teaching hospital. The Consultative Document did not say a certain sum had to be allocated to teaching hospitals. Teaching hospitals would lose contact not only with the centre but with the region. Dr. M.K. Strelling said it was vital to ensure that a special allocation of money was made for hospitals, otherwise funds would go to health centres and as block grants to local authorities. Hospitals would then suffer[1].

Other issues caused concern, namely the two-tier structure, area boundaries, employment of consultants and medical representation on working parties and study groups being set up in the wake of the Consultative Document. Dr. A.K. Tyler asked if it was accepted that there should be a two-tier structure, as in Wessex, it was thought that there should be some body to provide detailed administration at district hospital level, and it was hoped that it would be a democratically elected body. Dr. N. Strang said that the only reason for having boundaries in harmony with local government was to handle the division of the social services, which showed up the folly of that decision. Dr. J.S. Elkington said it was not clear who was to employ certain grades of staff. The committee had said that consultants and registrars should be contracted at regional level. The inference here was arealevel and the Welsh document said so specifically. At one point, feeling in the committee

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[1] Ibid., p. 26.

reached such a point that a proposal to reject the Consultative Document outright was made. However, the Chairman rejected such a move on the grounds that it was wiser to put forward criticisms and suggestions. He said he would be hesitant about rejecting the document outright because the profession might never get its viewpoint across[1].

The committee was not reassured on 16th December, 1971, when the chairman gave an oral report of a meeting between BMA representatives, the Joint Consultants' Committee and the Secretary of State, as Sir Keith Joseph's responses were not considered satisfactory[2]. A further cause for dissatisfaction was the activities of the Management Study Group set up by the Department to make detailed proposals on the management structure. The Chairman re-affirmed that clinical freedom would be guaranteed. However, he said that whilst it was recognised that there must be no hierarchical structure by which one doctor could command another, they might be monitored and co-ordinated by medical and non-medical administrators. The Chairman asked for the support of the committee in opposing this, as he considered it to be a very dangerous thing[3]. This support was readily given. Doubtless, partly because of the hostile reception accorded to the Management Study, the committee was addressed on 8th June, 1972, by Mr. Michael Alison, who clearly set out to give reassurance. He said that doctors must be involved

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[1] Ibid., p. 25.

[2] Ibid., 1972, p. 1.

[3] Ibid., 1972, pp. 56-7.

in management, and that he saw the profession playing a vital part in planning through strong advisory machinery at all levels of the NHS. He stated that no steps to implement any recommendations of the Management Study would be made until there had been full consultations with interested parties. It was fully recognised in the Department's proposals that professional freedom and clinical autonomy placed essential restraints on freedom to manage the health services. Replying to a question from Mr. A.H. Grabham, he said

> "There was a strong feeling that the whole of the health services should be placed in the hands of local government, but the Government had decided that health authorities should be distinct from local government. That was why there was to be in a centrally administered NHS a tier which would correspond to the delivery of social services and local authority services"[1].

Nevertheless, at its meeting on 28th September, 1972, the committee was still troubled by the accent on management in the White Paper. It was urged that funds allocated to domiciliary and community services must not be "at the expense of the already inadequate funds allocated to the hospital sector". It was also agreed that for an experimental period of five years that consultants and senior registrars were to be contracted to regional health authorities. It was hoped that it would be possible to press the case of registrars also. Only in the early summer had it become apparent that the Government had intended contracts to be held at area level, but the Joint Consultants' Committee and the CCHMS had pleaded with the Government for regional contracts, and even now the staff

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[1] Ibid., 1972, pp. 147-9.

of teaching hospitals under the AHA(T) arrangements would still be contracted at area level. This was accepted, but it was re-affirmed that all contracts should be at regional level. It was agreed that before the experimental period of five years expired, there would be a meeting with the Secretary of State to see if there was any evidence supporting a move towards that policy. The committee also re-asserted the Chairmen of medical advisory machinery should attend area health authority meetings, and be elected by their own members[1].

As with the general practitioners, hospital medical staffs had many of their demands met. No provision was made for monitoring and co-ordination of hospital medical staff, or a hierarchy of command amongst doctors, and the detested possibility of transfer to local government was avoided. The development of the regional tier owed much to the insistence of the CCHMS on regional contracts for consultants in order to avoid any possibility of their being contractually involved with area authority links with local government. Special provision was made for the teaching hospitals in the form of the AHA(T), though this was perhaps slightly weaker than the old boards of governors, and no special financial provision was made. Powerful medical advisory machinery was established, which tended to counter any disappointment felt at the lack of medical representation on area health authorities and regional health authorities, whilst at the level of the District Management Team, established by regulation as a result of

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[1] Ibid., 1972, pp. 6-7.

the Management Study, the consultant representatives gained a virtual veto as a result of the need for consensus decisions in the DMT. Although perhaps not as spectacularly successful as the general practitioners, the consultants certainly managed to maintain their dominant position in the NHS.

(d) The Public Health Committee

The Public Health Committee on the whole found itself able to concentrate on a narrower range of issues than the other committees. These issues were principally the role of the community physician, the conditions of transfer of public health doctors from local authorities to the NHS, and the position of the school health service. The committee at its meeting on 19th January, 1968, set up an ad hoc committee to consider the various memoranda and reports on the integration of the NHS[1]. This ad hoc committee was approved by the Council on 21st February, and it seems to have been the only one of the three committees to have its machinery approved in this way, perhaps an indication of its relative position.

At the meeting of the Council on 18th December, 1968, the Chairman of the Public Health Committee was able to report the views of the committee. The public health doctors were clearly more strongly in favour of integration and had fewer reservations than the other committees, and even than their own ad hoc committee. They wanted integration broadly on Green Paper lines, but felt that within each area health authority there should be a department of social health and epidemiology which, inter alia, would collect

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[1] Ibid., 1968, p. 31.

information on morbidity. It emphasised that there should be proper conditions of assimilation of public health doctors into the new service. In an interesting contrast with the other committees, the Public Health Committee reserved its position on recommendations opposing the transfer of the health services to local authorities.

> "The Association should not at the present stage take an irrevocable line in saying that the service should not be under any conceivable form of local or regional government. The committee preferred to leave the matter open until the report of the Royal Commission on Local Government was available"[1].

At the meeting of the Public Health Committee on 21st March, 1969, the Chairman was able to report the results of a meeting between a BMA deputation and the Secretary of State. A number of questions arose from the report, of which the most important were, first, was the Public Health Committee prepared to contemplate medical officers of health and public health doctors staying with local government whilst hospital and general practice doctors were unified in the NHS outside local government? The committee emphatically declined to accept any such situation. Second, what services would remain with local government? Whatever the division, the committee was clear that medical advice to local authorities must be given under statute by doctors from within the new unified health service. Third, there was the question of the proposed two-tier peripheral structure - would regional health boards be adopted, and would the three parts of the NHS be represented evenly?[2].

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[1] Ibid., 1969, p. 4.

[2] Ibid., 1969, pp. 10-11.

The Annual Conference of Public Health Medical Officers on 22nd March, 1969, also considered the position. It was concerned at the medical/ethical implications of Seebohm, whose proposals could not effectively be considered separately from those for NHS re-organisation, and for the re-organisation of local government, which were not yet available. It was reported that the committee were currently formulating views on the work of the future community physician. It was reported that the Secretary of State was now thinking in terms of a two-tier structure, and that the Special Representative Meeting of the Association in January had established the principles for re-organisation. Those concerning public health were :

(1) the new organisation should include social health and epidemiology, at area level as well as in collaboration with general practice and the district general hospital. This would provide sufficiently large units of population for the proper functioning of environmental and social health services;

(2) there should be proper conditions of assimilation of public health doctors into any new service; and

(3) there should be medical direction of all social work services with a predominantly health content and that any division between the health services and the welfare services should be avoided.

The Public Health Committee indicated its determination that all public health doctors should be included in any unified structure together with their colleagues in

general practice and the hospital service. If this integration were outside local government then it would be necessary for medical advice to be provided under statutory arrangements for local authority services by community physicians within the health service. There was no reason why this should not be done satisfactorily[1].

On 20th February, 1970, the committee discussed the second Green Paper. It wanted the functions of the community physician as set out in paragraph 51 of the Green Paper to be statutory, and agreed that on each area health authority and regional health authority there should be at least one member qualified in and practising community medicine. With regard to the implementation of the Seebohm Report, it re-affirmed its opposition, and urged that the medical officer of health should have control of all local authority medical services. In any event, if it was to be implemented, it should be at the same time as re-organisation of the NHS and local government. It was pointed out that it was BMA policy that the Chief Administrative Officer of the health authorities should be a doctor, and that Mr. Crossman had promised a paper on this which he had never produced. The proposed Central Advisory Council should not interfere with established consultative machinery, and alarm was expressed about it being used as an alternative source of advice to the BMA "to break the power of the doctors". It also suggested that doctors should be employed by or contracted to area health authorities[2].

At the meeting on 27th March, 1971, the issue of the

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[1] Ibid., 1969, p. 5.

[2] Ibid., 1970, pp. 75-6.

school health service was raised. The Local Education Authorities wanted the exclusion of the school health service from the re-organised NHS, and had suggested in their document that if they were not satisfied after discussions, they might wish to appoint their own professional staff. The Chairman expressed the view that it was absurd to try to separate the school health service out of the main stream of medicine. A motion was carried that local authority personal health and school health services must be transferred to the new NHS as one unit together with all staff deployed therein and all medical guidance to local authorities must be rendered by or through community physicians employed by the NHS. The committee also sought the inclusion of the child guidance service in the NHS[1].

On 2nd July, 1971, the committee considered the report by the Council on the Consultative Document. It noted the absence of any reference to a Staff Commission to handle transfer, and it proposed a motion to go to the Special Representative Meeting, assuming one would be established. It was also pointed out that the Special Representative Meeting in May, 1970, had affirmedall hospital staff above SHO should be contracted to regional authorities. The Council of the Society of Medical Officers of Health thought all doctors should be appointed by the same authority, and this meant that all salaried staff not in the hospital service should be contracted at regional level[2].

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[1] Ibid., 1971, p. 8.

[2] Ibid., 1971, p. 31.

The committee discussed the Management Arrangements in the Grey Book on 29th September, 1972. It wanted two Community Physicians on the District Management Team instead of one on the grounds that one doctor could not cope with the work involved. It also argued that the Community Physician must have access to medical records for epidemiological and school health purposes, and health planning purposes. The committee also agreed to suggest to the Working Party on Collaboration on right of direct access by the Community Physician to the local authority on matters of health, without intervention by any local authority officer[1].

The Conference of Public Health Medical Officers on 3rd March, 1973, proposed that the school health service should stay as part of the community medicine structure and not be hospital based. It was also pointed out by Dr. Rosemary Graham that general practice was not geared to take on the total supervision of children, and paediatric departments were not training their future specialists in community medicine. "Reality demanded a trained corps of doctors relating to both general practice and hospital medicine but applying their special expertise to children in the community"[2].

The role of the Public Health Committee seems relatively sketchy, but it must be borne in mind that the Society of Medical Officers of Health might have been more significant. It is perhaps a measure of partial failure that little was achieved in the way of statutory definition

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[1] Ibid., 1972, pp. 8-9.

[2] Ibid., 1973, p. 83.

of the functions of the Community Physician. However, the school health service was transferred to the NHS, though not the child guidance service, and the Community Physician was given a considerable place as District and Area Medical Officer, and possibly as Regional Medical Officer under the Management Arrangements, though not the position of Chief Administrative Officer. Given the rebuff the medical officers of health had suffered in the Seebohm Report, potentially at least, they retrived a great deal.

(e) The Council of the BMA.

The BMA Council can therefore be said to have faced three difficulties in attempting to formulate an agreed and coherent policy in relation to the re-organisation of the NHS. First, it found problems arising from the Seebohm Report which differentiated between services based on social work skills and medical skills, a division which was implemented by the Local Authority Social Services Act, which the BMA opposed and sought to have amended during its passage through Parliament. It may be argued, however, that the BMA only realised belatedly the importance of the Seebohm Committee's deliberations. Its evidence to that Committee was given by a group of medical officers of health accompanied by one general practitioner, whereas the Committee would have preferred evidence from general practitioners as they were also to receive evidence from the Society of Medical Officers of Health[1]. The lack of realisation of the need for the evidence of general practitioners may be indicative of the BMA's attitude to

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[1] Minutes of the Seebohm Committee, 28th October and 11th November, 1966.

to the Seebohm Committee's deliberations at this stage, and it was later to regret the result.

Second, the Council found that the Porritt Report placed it in a difficult position politically, as although the BMA had never wholly accepted the report officially, and the General Medical Services Committee had certainly never accepted it, it did imply some commitment to the idea of re-organisation on the part of the medical profession. As Dr. J.H. Marks pointed out to the Special Conference of Representatives of Local Medical Committees, the BMA Working Party on NHS Administration, which had included the leaders of the GMSC, had, in 1969, pointed to the tripartite division as inefficient, wasteful of manpower etc., and this had been amply demonstrated by Porritt. The Working Party had said that nothing which had happened since 1958 had persuaded it that this view was exaggerated. "A few days later the Green Paper had been published, and in the panic that followed all that sound reasoning was forgotten"[1].

Third, there was the difficulty of reconciling the conflicting interests of the three main standing committees of the BMA. At the Council meeting on 18th December, 1968, the different concerns of the standing committees came out in their views of the first Green Paper as put forward by the respective chairmen. Dr. R.M. Mayon-White, Deputy Chairman of the CCHMS, indicated that his committee was unable to accept the concept of area health boards. The Green Paper was not in the best interests of the Hospital Service. The first step should be to experiment with

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[1] B.M.J., Supplement, 1969, pp. 37-47.

integration in the existing structure. The Committee did not approve the methods proposed for appointing board members, and would be strongly opposed to boards being administered by local authorities. It was feared that a large number of boards might lead to the needs of teaching and research being subordinated to the day to day needs of hospitals. Dr. J.C. Cameron, Chairman of the GMSC, pointed out that neither the Conference of Representatives of Local Medical Committees nor the GMSC had accepted so far the thesis that unification even on the lines of Porritt was acceptable. It was feared that the Green Paper put in peril the independent contractor status of general practitioners. Dr. C.D.L. Lycett, Chairman of the Public Health Committee, suggested that the views of public health doctors on integration were more strongly in favour, and had fewer reservations than were set out in the report of the Council's ad hoc committee. The Public Health Committee wanted integration broadly on Green Paper lines, but there should be within each area health authority a department of social health and epidemiology. There should be proper conditions of assimilation for public health doctors into the new service. The Public Health Committee reserved its position on the Council's proposed recommendation to a Special Representative Meeting opposing transfer of health services to local authorities. "The Association should not take an irrevocable line in saying that the service should not be under any conceivable form of local or regional government". The committee preferred to leave the matter open until the report of the Royal Commission on Local Government was available[1].

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[1] Ibid., pp. 3-4.

Some of these difficulties became apparent during the course of the Council's discussions of a report from the Welsh Committee which suggested that a pilot scheme relating to area health boards ought to be tried in Wales. After much hesitation and heart-searching, the Council agreed to publish the suggestion as a discussion document in January, 1968. The CCHMS was unhappy about some matters in the proposed document, and some fear was expressed that it might be taken as BMA policy. Dr. R.B.L. Ridge thought that the Minister had made his announcement (concerning the departmental inquiry into the possibility of re-organising the National Health Service) because the Royal Commission (on Local Government) and the Seebohm Committee were at work. "If the Minister uses the opportunity to play off the report of one of these bodies against the other, and the Welsh Committee is relying on Ministerial action to forward its particular case, then we may in fact be bogged down worse than ever"[1].

Initially, however, the Council welcomed the Minister's announcement that his department was looking into the possibility of re-organising the NHS, and took the opportunity to press for an inquiry into the financing and organising of medical care. The Minister would be asked for an opportunity to discuss his proposals with him, although it is unclear whether this was the "immediate consultation" suggested by the Chairman, or the "consultation forthwith" demanded by Dr. J.S. Ross. The secretary, Dr. Stevenson, suggested that it would be preferable to see

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[1] Ibid., pp. 65-6.

the Minister first and ask for a discussion on all the relevant matters[1]. In the event, it seems clear that no such consultations in fact took place. At a later meeting, on 2nd October, 1968, the Chairman of Council refuted any suggestion that the BMA had negotiated the Green Paper with the Government. "This is utterly and completely untrue, we have had no discussion with nor have we been near the Ministry at all concerning the contents of the Green Paper". However, in the meantime, the Council appointed a working party to bring Porritt up to date[2].

The Annual Representative Meeting of 24th June, 1968, was informed of these developments, and approved a motion that there should be an independent inquiry into the finance and administration of the Health Services, as in that way, it was argued, there could be an unbiased examination of the provision of health services. Dr. I.M. Jones expressed the view that sooner or later there would be some form of independent inquiry, probably a Royal Commission, as the matter was "so politically hot". The Chairman of Council told the meeting that the special working party, which had been in a way a planning unit, had been set up to produce a report for discussion by Divisions and Branches on how the Health Service should be administered. When the replies were received the Association would be able to formulate policy[3].

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[1] Ibid.

[2] Ibid., 1968, p. 5.

[3] Ibid., 1968, p. 18.

By the time of the meeting of the Council on 2nd October, 1968, the report of the working party had gone to branches and divisions for discussion , and the Standing Committees were considering the Green Paper. The GMSC was to hold a Special Conference of Representatives of Local Medical Committees. This committee had expressed serious misgivings about certain of the proposals in the report of the working party, and could not agree at present to the report being used "to provide guidelines for the Association's representatives, allowing them a degree of flexibility in their discussions with the Ministry", as was suggested in the report. Dr. R.B.L. Ridge indicated that there were two issues that concerned general practitioners. First, there was the question of a unified administration in which the profession would not participate, and second, the implementation of the Green Paper proposals would make a salaried service for family doctors inevitable. "This is a resignation issue. It is 1948 all over again". Dr. R.L.Luffingham indicated dislike of the Minister setting the pace, and considered it essential that a Special Representative Meeting was held. At the moment the BMA was uncommitted. He took up the belligerent stance which was to characterise the approach of some BMA members during the re-organisation process.

> "When we know what we are to fight about, which the SRM will tell us, we shall know how to do it. This is the only resignation issue facing the profession at the moment. It is all very well for the Minister to set up a new administrative structure. If the profession does not want it, it will not sign its new contracts, and if it does not sign its contracts the administrative structure will not work".

The Council agreed to call a Special Representative Meeting when the Scottish Green Paper had been published; to set up a working party consisting of the Chairman of Council, and the Chairmen of Committees preparing reports, with power to co-opt, whose task would be to correlate the reports from the committees in the first instance; and to send a letter to the Minister of Health pointing out that the BMA's programme for considering the Green Paper would take time[1].

The Special Representative Meeting was held on 30th January, 1969, and found the main proposals of the Green Paper unacceptable. It was agreed that the existing tripartite structure should be retained until a suitable alternative was accepted by the profession, and that there should be no transfer of the NHS to local authorities in any form "which would subject the NHS to local government pressures". The Council placed before the Meeting thirteen recommendations drawn up by its working party, some of which were clearly designed to take account of the varying interests of the standing committees. These recommendations included reference to the maintenance of absolute confidentiality between patient and doctor and doctor and doctor; maintenance of the clinical independence of the doctor; the relationship between Government and the medical profession should be one of genuine partnership - providing for agreement in planning and participation in administration; there must be no direction of doctors to practise in particular areas, save the present Medical Practices procedure; the maintenance of the right of any doctor to practise wholly or partially outside the NHS; the maintenance of the

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[1] Ibid., 1968, p. 7.

independent contractor status of the family doctor, with no future changes in methods of remuneration which would create advantages for a salaried practitioner which could be detrimental to the independent contractor; the medical supervision of all social work services with a predominantly health content and purpose as well as all paramedical services; the necessity for any new organisation to include social health and epidemiology at area level; the need for proper conditions of assimilation of public health doctors into any new service; the necessity for provision for active and effective representation of doctors by doctors at the appropriate levels in all planning and administrative units; the necessity for adequate participation by the community in the administrative units; the necessity for adequate provision for medical education and research with special provision for those areas in which medical schools are located; the necessity for the chief administrative officer to be medically qualified; and the separate and adequate financing of each branch of the Health Service as a pre-requisite to any change in the administrative structure. Nevertheless, it was also recommended

> "that provided that satisfactory safeguards on the preceding major points of principle are obtained the Representative Body should re-affirm its support for the principle of unification of the administration of the Health Services"[1].

The Annual Report of Council pointed to the wisdom of laying down these basic principles, as shortly afterwards the Secretary of State had announced that he had taken note of the criticisms he had received and proposed to issue

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[1] Ibid., 1969, pp. 55-68.

another Green Paper. He had been impressed both by the unanimity of the criticisms of the 40 - 50 Area Boards proposed in the first Green Paper - small appointed bodies with little if any community or professional representation - and by the measure of support for a two-tier system with the effective control of the Service at district level with an opportunity for the local community and the professions engaged in the Service to participate in its management. He also made it clear that some re-organisation of the NHS could not wait upon local government reform, which might take up to five years to implement, but must be settled "on its own" as a matter of urgency. This appeared to rule out any thought of transfer of the NHS to local authority control, a course against which the profession had resolutely set its face, but equally made the complete transfer of local authority health and social services to the NHS more difficult to achieve. The Annual Report indicated that a preliminary meeting had been held with the Secretary of State at which he had made it clear that he wished to have detailed consultations with the profession before he published the second Green Paper.

> "In effect he has invited the profession to help him in taking the first step towards an integrated service at district level. The Council for its part has invited its major Standing Committees to examine this new situation and to offer guidance as to whether it is possible to formulate proposals of this kind without departing from the principles already established by the SRM in January. .... Meanwhile the Council wishes to give an assurance that it will in no way commit the profession to any new proposals which are contrary to the Representative Body's policy which was so clearly established in January"[1].

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[1] Ibid., 1969, p. 30.

Dr. R. Gibson, Chairman of the Council, was able to tell the Annual Representative Meeting that the Secretary of State had been sent a copy of the principles agreed by the Special Representative Meeting in January, and had invited the Association to discuss them with him. He had dissented little from them, and told the Association's negotiators that he had come to certain broad decisions. Firstly, it was probably politically impossible either for the new regional authorities proposed by Redcliffe-Maud to take over the existing health services, or for the Health Service to take over all the health functions of the local authorities. Secondly, it would probably be at least five years before the Government could give effect to any major reform of local government and he thought that the Health Service administration should not stagnate for that length of time and some earlier re-organisation was inevitable. Lastly, he had accepted the BMA's views on full community and professional participation in the administration, and indicated he would favour a two-tier peripheral administrative structure. The Council thought its role should be to continue discussions with the Secretary of State on all matters of administrative reform, guided by the general principles laid down by the Representative Body. It would be impossible to finalise any discussions if at each stage the Council had to come back to the Representative Body for further instructions. The Meeting should allow negotiators to carry on discussions within the principles laid down until the second Green Paper was published. The Council would then be able to judge how closely the new proposals matched up with the principles laid down. If there were wide

disparity the Council would seek guidance from the Representative Body[1].

Over the late summer there were meetings between the Government, BMA and the Local Authority Associations about the future administrative structure of the health services, and these were reported to the Council by the Secretary. The matter had been complicated by the intrusion of the Seebohm Report. It was clear to the BMA representatives that the Government was under pressure to give effect to the recommendations of the report in whole or part at an early date. The BMA had been trying to find out from the Local Authority Associations whether it was possible broadly to separate those local authority welfare services which had a medical content and which could continue to be administered by the public health service, and those which ought to be administered by the social service departments. The BMA had said throughout the discussions that if the Government implemented the Seebohm proposals in whole or part without at the same time announcing its intentions on the re-organisation of local government and on the unification of the health services then the medical profession would react strongly. The Secretary suggested that the BMA must either press for deferment of the implementation of the Seebohm proposals, or failing that, for the most explicit undertakings from the Government that further talks on the unification of the NHS would be on the clear understanding "that they were out with the proposals of the Redcliffe-Maud Report". It was reported that the Secretary

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[1] Ibid., 1969, pp. 81-2.

of State had agreed to see BMA representatives again shortly to say how far the Government was prepared to go to meet the BMA's wishes. Dr. C.D.L. Lycett emphasised that efforts had been made to ensure that if the Secretary of State did implement Seebohm it would only be in part. That was important because if more than a lesser part of Seebohm was implemented, important health services would be lost not only to the departments of medical officers of health but to the unified health service of the future. Therefore it was necessary to do everything possible to ensure that services of mainly health importance should not be included in a social services department. The principles underlying Seebohm were a negation of medical progress over the last 25 years or more, which had been towards seeing the patient as a whole, including his family and social surroundings. The Seebohm thesis was that matters outside the strict confines of medical diagnosis and treatment in the narrow sense were the concern of somebody else[1].

The Chairman of Council reported on further meetings with the Secretary of State at the meeting of Council in November. The Government proposed to publish a White Paper on local government to be followed immediately by a Green Paper on the unification of the health services. "Ample time would be guaranteed for full consultation with the profession on the second Green Paper". Meanwhile the profession's representatives were under an obligation to regard the talks as confidential, but the profession had in no way been committed[2].

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[1] Ibid., 1970, pp. 17-20.

[2] Ibid., 1969, p. 14.

The publication of the second Green Paper again found the Council in difficulties, in spite of the consultations which had taken place. The Council's Co-ordinating Committee had co-ordinated the views expressed by the Standing Committees on the Green Paper, and a draft report was presented to Council for approval before going to a Special Representative Meeting. Nevertheless, divergent views were expressed at the Council. Mr. S. Walpole Lewin said his committee rejected both the philosophy and detail of the second Green Paper. It did not agree with the proposed area health authorities, regional health authorities or district committees. It would therefore be in great difficulty if Council thought the Representative Body should accept the Green Paper. Dr. J.C. Cameron said that the GMSC would be reporting to a Special Conference of Representatives of Local Medical Committees that the second Green Paper formed a basis for negotiations. If that were accepted by the Special Conference then the GMSC would say the Green Paper was acceptable as a basis for discussion. Dr. C.D.L. Lycett said that in general the Public Health Committee accepted the second Green Paper. It recognised that it was a compromise document, and would accept it in general as being probably the best compromise from the profession's point of view which it was likely to obtain. From the public health service point of view it was necessary to have integration of the health service as soon as it was reasonably possible. The Public Health Committee would be unhappy if the second Green Paper was rejected as a basis

for discussion[1].

The Council's embarrassment was reflected in its failure to recommend either acceptance or rejection of the Green Paper. Instead, it called attention to the differences between the views of the hospital doctors, and those of the general practitioners and the public health doctors. Its recommendations to the Special Representative Meeting did note with satisfaction the acceptance of the Representative Body's view by the Government that the administration of the NHS should not be transferred to local authorities. It also recommended that not less than one-third of the seats on all the new administrative authorities should be reserved for elected representatives (preferably doctors in active practise) of the medical profession. It favoured the two-tier system, and recommended that all medical staff providing advice or services for local authorities should be employed solely by, or in contract with, area health authorities. An appendix to the Council's recommendations on the future of Public Health and the role of the Community Physician emphasised the importance of preventive and social medicine and the important role of the new Community Physician, as well as urging attention to safeguarding the redundancy of local government medical officers[2].

The Annual Report of Council returned once again to Seebohm. It pointed out that the Council had consistently

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[1] Ibid., 1970, pp. 17-20.

[2] Ibid.

pursued the policy laid down by the Representative Body that those services with a predominantly health content should be under medical control.

> "It is however, impossible to separate health and social services completely and wherever the line is drawn there would be room for argument. Certainly the Council is not satisfied with the division of responsibilities set out in the Green Paper and the Local Authority Social Services Bill, and would seek every opportunity to obtain amendments in the Bill".

It also pointed out that the implementation of the Seebohm Report in advance of the integration of the NHS brought obvious difficulties for public health medical officers, and from their point of view "it is desirable that the interval between the two events should be as short as possible". The BMA had tried to obtain amendments to retain under present health committees, all functions under S22 of the National Health Service Act, 1946, except for day nurseries and childminders, subject to the continuation of the responsibilities of medical officers of health for assessment and care of handicapped children, and for general medical supervision; the prevention of illness and care and after care of the sick, together with the welfare of mentally disordered persons; provision of accommodation for children suffering from mental disorder; arrangements for welfare of mentally disordered in hospital and supervision of residential homes for them under S12 Health Services and Public Health Act, 1968 and Mental Health Act, 1959 and the domestic help service under S29 of the National Health Service Act, 1946. The object of this was to retain these services under medical control with a view to subsequent transfer to the administration

of the NHS on re-organisation.

> "Steps are also being taken to ensure that the date of implementation of the provisions in the Bill should not precede the operative date of any re-organisation in local government or of the structure of the NHS"[1].

The Special Representative Meeting of 6th-7th May decided that the BMA would negotiate on the second Green Paper. However, probably at least partly as a concession to the CCHMS, it was agreed to seek a number of amendments. Those likely to be of particular interest to the CCHMS were increased powers for the proposed regional councils in planning and administration; agreement by the Government that one for one matching of areas with the new local authorities might be varied; special consideration to be given for medical schools and teaching hospitals; and the CCHMS particularly wanted registrars and above to be contracted to regional health authorities. The general practitioners thought that the proposed statutory committees adequately preserved their independent contractor status[2].

The Annual Report of Council for 1970-71 reflected the changed situation arising from the change in Government. It reported that the new Secretary of State had announced he intended to re-organise the NHS outside local government at the same time as local government was re-organised, on 1st April, 1974. The Secretary of the BMA had immediately offered to resume discussions which had been interrupted by the General Election of June, 1970. The Secretary of State had replied that he intended to hold discussions with health

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[1] Ibid., 1970, p. 38.

[2] Ibid., 1970, pp. 111-16.

service interests and would advise the Association as soon as he was ready to do so.

> "It is understood that a consultative document will be ready shortly, to be followed in the early summer by a White Paper, the Government's intention being to introduce legislation on the subject before the end of the year"[1].

When the Consultative Document was received, the Council was somewhat perplexed. It was critical of the lack of time given for sending in comments. It expressed fears about the vagueness of the document, its constant emphasis on management, and the inadequate provision made for participation by doctors in running the reformed NHS "could be detrimental to the patients' interests"[2]. The Special Representative Meeting in July endorsed these views[3], and the Secretary of the BMA in a report printed in the same month pointed to the difficulties experienced by the Special Representative Meeting. These were the lack of time for discussion, and the fact that the Government's proposals were sketchy in the extreme, and that much of the detail had been left to two working parties, which had only recently held their first meetings.

> "It is clear, however, that if the views of Government have changed, the views of the profession have not. The Representative Body re-affirmed its views that in addition to the professional advisory machinery envisaged in the Government's Consultative Document, there should be adequate representation of the healing professions on the authorities themselves both at regional and area level, with at least one-third of the total membership being medical. In so doing it rejected the Government's idea of

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[1] Ibid., 1971, pp. 44-5.

[2] Ibid., 1971, p. 11.

[3] Ibid., 1971, pp. 97-107.

> small governing bodies - the members chosen primarily for their managerial expertise - with only minimal representation of the profession".

The Secretary argued that this was a matter of first importance for doctors.

> "The Service was first established on the basis of partnership between the Government and the professions. How such a partnership can continue without the profession playing a full part in the administration of the Service is difficult to see, and the professional advisory machinery offered by the Government, though necessary, was not acceptable to the Representative Body as any kind of substitute. Indeed, the representatives made it clear that they wanted the advisory machinery family in the hands of the profession, with its functions and right to consultation clearly spelt out. The Government has stressed that its document is, as its name implies, Consultative. We have sent the BMA's views to the Secretary of State and we are now awaiting the promised consultation"[1].

On 1st December, the Chairman was able to report to Council "one of the more satisfactory meetings" with the Secretary of State which had taken place on 1st November. The profession had been represented by Mr. Walpole Lewin, Dr. C.E. Astley, Dr. J.C. Cameron, Dr. C.D.L. Lycett, Dr. R.B.L. Ridge and the Secretary. Sir John Richardson, Mr. J.H. Hovell, Lord Rosenheim, and Sir Thomas Holmes Sellars were also in attendance. The BMA representatives expressed concern about two major issues. First, there was a need for consultation before those matters referred to the two working parties had been translated into a White Paper. The second was the concept of management as portrayed in the Consultative Document. The Chairman reported that he had asked for assurances that the profession would have the opportunity to make written and oral submissions to the

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[1] Ibid., 1971, p. 115.

Working Parties, and that he had also asked for consultations before the results of their studies were embodied in a White Paper. It was emphasised that the skeletal nature of the Consultative Document itself made consultation at that stage essential. The Secretary of State was initially reluctant to agree, but on being reminded of a previous undertaking to consult before publication, he said he would consider further how he might best meet the wishes of the profession with the minimum of repercussions and delay. Sir Keith Joseph had promised to come back with proposals. The importance the profession attached to early consultation had been again emphasised strongly[1].

However, in April, 1972, the Council still found itself in some difficulty in discussing NHS re-organisation properly because

> "the Council was faced with commenting on hypotheses and possible proposals and not on any formal policy declaration by the Government. Once the Government formally declared its policy, then of course the Association would prepare a definitive answer".

In the meantime, any views sent to the Department of Health at present would have a covering letter pointing out that the Association's comments represented its present views on the questions being discussed, without prejudice to the future, and without prejudice to official comment which would be made by the BMA when the White Paper was published and formal policy documents were issued.

> "We have to decide today whether we sit tight and say nothing until the moment arrives, or whether as these various studies take place up and down the country, we may, by sending in

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[1] Ibid., 1971, pp. 59-60.

interim papers seek to influence thinking in the hope that when the legislators come to their final decisions, what they decide may not be too far off what we have in mind"[1].

The Annual Report of Council for 1972 indicated the current concerns of the Association. It noted that the Secretary of State had given no indication that he intended to defer to the profession's request for a substantial increase in medical representation on the new administrative bodies. On the question of the professional advisory machinery, he had promised a paper setting out the Department's views as a basis for discussion. This had been received, and the Council had sent its comments to the Department. The Secretary of State had given an assurance that before the recommendations of the Management Study Group and the Working Party on Collaboration were accepted and put into effect, there would be "prior consultation with the appropriate interests, including the Joint Consultants Committee and the British Medical Association". However, as it was not expected that the Study Group and Working Party would each produce a single final report, the Secretary of State had suggested that it would be a question of consultation "as we go along"[2].

This gave rise to a considerable bone of contention between the BMA and the Department. During January, it had come to the notice of the Association that the Management Study Group had drawn up certain "tentative hypotheses" relating to the management structure which it planned to

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[1] Ibid., 1972, p. 68.

[2] Ibid., 1972, p. 79.

subject to field tests. A document relating to this was circulated to the General Purposes Committee of the Staff Side of the General Whitley Council. The BMA and the Joint Consultants protested that in spite of the Secretary of State's promise of consultation they had been by-passed in favour of a body on which the medical profession had only marginal representation, and which was not a normal channel for consultation and negotiation with the profession. Subsequently, the document was released for consideration by the Association's committees, and it was asserted by the Department that it represented no more than ideas which were to be investigated, and that when the stage was reached when firm proposals were made, then there would be full and proper consultations on them with the profession through the normal channels. However, the late release of the document meant that by the time the Council reviewed the situation, the field trials had already started, and the Standing Committees had been unable in the time available to give detailed consideration to the Document. The Council informed the Secretary of State that the results of the testing could not be regarded either as valid evidence of their viability or non-viability, or as proper "consultation" with the profession. The doctors involved in the field trials were reminded of BMA policy on the re-organisation, and of the need to examine the management hypotheses presented to them with extreme caution. They were also invited to a conference at the BMA for an exchange of views after which a paper setting out "guide lines" was issued to them. Subsequently, the Council had an opportunity of studying the Management

Study Group's document in detail, and sent its comments to the Department, but the incident rankled for a long time[1].

By this time, as the Council's report pointed out, the destiny of the School Health Service was also causing concern. The Association had drawn up a memorandum re-inforcing the Association's policy that the Service should become part of the NHS on re-organisation. The memorandum was sent to the Working Party on Collaboration, and oral representations were made to the Secretary of State on the need for the School Health Service to be transferred to the NHS as part of an integrated child health service. The question of the assimilation of public health medical staff was also being raised, and the Council had re-emphasised its belief that all public health medical officers currently providing advice or services for local authorities should in future be solely employed by, or in contract with, area or regional health authorities. It was also emphasised by the Annual Representative Meeting that consultants should be under contract to the regional health authority, which was CCHMS policy[2].

The Government's approach to re-organisation continued to puzzle the Council. The Chairman said at the meeting on 1st November, 1972, that the Co-ordinating Committee had looked at reports from the three main Standing Committees on current aspects of re-organisation together

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[1] Ibid.

[2] Ibid., 1972, p. 75.

with the resolutions of the Annual Representative Meeting of 1972. Nowhere could the Committee find a "broad attitude" to what was going on - whether one of welcome, rejection, surprise or even disbelief[1]. The following month the Council learnt that the Chief Officers had examined the NHS Re-organisation Bill and prepared a list of amendments in line with policy decisions taken by the Representative Body on the several occasions on which the matter had been discussed. The Secretary of State had been advised of the amendments the BMA was seeking and it was hoped that Government support would be obtained. A further meeting with the Secretary of State had been arranged for the second week in January to consider any further amendments which might come from the Standing Committees studying the Bill[2].

The Secretary of the BMA reported progress to the profession in a "BMA Letter to the Profession". He was able to claim "We have achieved a great deal. As the following paragraphs will show, much of the policy laid down by the Representative Body is already incorporated in the Bill". There would be no interference with clinical freedom by 'management' or the new NHS ombudsman. Nevertheless, although the official report on management stated that "consultants and general practitioners must have clinical autonomy so that they can be fully responsible for the treatment they prescribe for their patients", and the Secretary of State had also given his personal re-assurance

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[1] Ibid., 1972, p. 32.

[2] Ibid., 1973, p. 2.

"on this vital issue", the Council thought that it would be prudent to embody the principle of clinical freedom in the Act, and had promoted an appropriate amendment to this end. The Council had also promoted an amendment to provide a minimum proportion of medical members on the new authorities, and had also insisted upon the necessity for strong medical advisory machinery and model constitutions for medical advisory committees at district, area and regional levels being negotiated with a view to their official recognition under the Bill. The Council had also promoted an amendment to impose upon the health authorities a statutory obligation to consult the recognised medical advisory committees.

The Secretary also pointed out that the steps taken to ensure that the independent contractor status of the general practitioner would be preserved had been successful. The general practitioner in the new arrangements would not be in contract with the area health authority but with the family practitioner committee which would be very similar to the executive councils. After consultations with the Secretary of State, the Council had secured strong regional authorities and contracts for senior medical staff in non-teaching areas were to be held at regional level at least for the next five years. Special provisions were also going to be made for teaching hospitals to safeguard teaching and research. However, the Council was still concerned about hospital social workers, and would seek to amend the Bill to ensure that social services in hospitals were not impaired by their impending transfer to the social service departments of the local authorities. The Bill provided for the transfer of the school health service to the new health authorities, which met the view the BMA had always strongly held.

However, the Council was seeking to promote an amendment to ensure that the new local authorities would obtain medical advice and services from doctors in contract with the new health authorities and through the agency of the community physicians.

The Secretary therefore felt able to say

> "On many matters of established BMA policy it has already been successful and on others will be promoting amendments to the Bill during all phases of its progress through Parliament".

He went on to say however,

> "the Bill is not the end of the story and we know that during the greater part of this year there will be a host of regulations and directives on various aspects of the new administration on which we have been promised full consultation"[1].

The medical profession were principally represented in the House of Lords by Lord Amulree, Lord Brock and Lord Platt, and these peers sought to obtain the amendments to the Bill desired by the BMA. These concerned the statutory recognition of clinical freedom, the securing of greater medical representation of health authorities, the imposition upon health authorities of a statutory obligation to consult the medical advisory committees, and preventing the transfer of medical social workers to the local authority social services.

Early in the Committee Stage, Lord Brock attempted to secure the passage of an amendment to the Bill which was aimed at attempting to secure clinical freedom for the medical profession. He recognised and accepted the assurances given by the Secretary of State on this matter

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[1] Ibid., 1973, pp. 29-30.

"but we have to think of a possible successor who might not have such good intentions". However, the amendment was rejected by Lord Aberdare on the grounds that there was no intention on the part of the Government to interfere in matters of clinical freedom, and that in any case, the amendment was too loosely worded and might be interpreted as impinging upon the Secretary of State's responsibilities and accountability for determining policy. Lord Brock returned to this theme on Report Stage when he proposed a re-worded amendment backed by Lord Amulree and Lord Platt. However, Lord Aberdare again rejected the amendment, this time on the grounds that as now worded the amendment might relate clinical freedom to the actions of medical administrators and inhibit the carrying out of administrative instructions given by the Secretary of State. In the face of Lord Aberdare's opposition, Lord Brock withdrew his amdndment.

Lord Brock also attempted to secure greater representation of the medical profession on health authorities, quoting the existing Boards of Governors and Regional Hospital Boards as precedent. Lord Aberdare also rejected this amendment on the grounds that what was wanted was people with different backgrounds, interests and talents. The medical profession would undoubtedly be represented, but this could be left to the good sense of the Secretary of State. He also pointed out that medical advisory committees at all levels were now to receive statutory recognition.

> "I am sure the noble Lord will know that we are in close consultations now with the medical profession and discussing just how these medical advisory committees can best be set up to ensure

that essential medical advice is available at all levels".

The medical advisory committees were themselves the subject of an amendment put by Lord Platt in the Committee Stage, this time with success. This amendment was designed to lay the statutory obligation of a general duty of consultation of advisory committees by health authorities. This was agreed and accepted by Lord Aberdare. This was further strengthened by an amendment accepted on Report to give the ultimate responsibility and power of recognition to the advisory committees and the suitability of their composition to the Secretary of State and not the health authorities.

Finally, on Report, Lord Amulree moved to prevent the transfer of medical social workers and psychiatric social workers to local authorities, and he was supported by Lady Ruthven and Lord Platt. In reply, Lord Aberdare pointed out that the Working Party on Collaboration wanted them to be transferred, although the medical members of the Working Party had disagreed. He indicated that the Government had made no final decision yet, and that the clause in the Bill was permissive, and did not provide any definite date of transfer.

There is no evidence that the BMA pursued the questions of clinical freedom and the transfer of medical social workers when the Bill entered the House of Commons. The question of the medical social workers was taken up in the Working Party on Collaboration, and the decision to give effect to the transfer was hedged around with safeguards.

There was to be a standing sub-committee of the relevant Joint Consultative Committee to supervise the arrangement and a senior officer in the social services department responsible for providing this service to the area health authority. In addition, the local authorities gave an undertaking not to alter existing staffing levels without consultation or to move staff out of hospital employment without their consent. Local authorities also agreed to advertise specialist hospital posts in future and to provide a guarantee of security for new staff accepting these posts. However, the medical members of the Working Party failed to win executive responsibilities for JCCs, AHA representation on relevant local government committees, or effective default provision on the social services side either through AHA provision as an alternative or through intervention by the Secretary of State. The traditional independence of local government may have exerted an effective influence in providing barriers to these invasions.

(f) Conclusion.

In any assessment of the relative gains of the pressure groups involved in the re-organisation of the NHS it is difficult to avoid the conclusion that the immediate advantage lies with the medical profession. Virtually all the major concessions demanded were granted including the maintenance of the independent contractual status of the family practitioner, a strong regional tier to which consultants would be contracted, strong statutory medical advisory committees at every level, no local government control of the NHS and provision by the NHS of the School Health Service. By contrast, local government received few concessions. These were principally co-terminous boundaries between counties or metropolitan districts and area health authorities, collaboration machinery through Joint Consultative Committees, minority representation on area health authorities and the possibility of some representation on regional health authorities. It failed to obtain control of the NHS, lost its remaining health services including the important School Health Service, failed to secure a role for itself as the representative of the consumer interests or to take the community health councils under its wing.

The reasons for this disparity in achievement are not hard to find. The BMA had better access to the points of decision-making in the DHSS than local government as the main provider of expertise and skills in the health field, whereas public health suffered from low prestige and status as part of the local government sector. Further, once

local authority personal social services had been re-organised on the exclusive basis of social work skills it would have been difficult to deny the medical profession the right to a dominant voice in the re-organisation of the NHS. The medical profession was also in a better position to manipulate relevant cultural symbols. These included such issues as "confidentiality", "doctor/patient relationships", "clinical freedom" and "preserving the role of the family doctor". As against this, the call made by local government for "democracy in the NHS" was not a potent one. This could be portrayed by the BMA as meaning local government control at a time when the public at large shows little interest in the democratic aspects of local government, and when local government tends to have a poor image. As one local government participant in the re-organisation of the NHS put it "The public were not interested. There was nothing on television". Another said "Local government has a bad image. Would the electorate have it? Would they have wanted hospitals to go back?". The "relevant publics" in Government and Parliament and public opinion at large was not likely to be persuaded that it was advantageous to put the NHS back into local government at this time. Hence, the Local Authority Associations never contemplated mounting any sort of public campaign when consultation with the DHSS failed them and Parliament proved relatively uncympathetic. There was no evidence that it would have served any purpose.

However, looked at from another point of view, it is not quite so clear that in the long-term the balance of advantage can be determined so easily. The medical

profession found it difficult to speak with a united voice and there was a variable level of achievement by the different sections of the profession. The family practitioners gained most by retaining their independent contractual status through what were virtually the old executive councils re-named Family Practitioner Committees. The consultants gained their strong regional tier and contracts tied to this tier although this provision is to be reviewed after five years. Special provision was made for teaching hospitals through the AHA(T), but it is not clear what this amounts to in practice. The medical officers of health were successful in securing the transfer of the public health sector to the NHS and in establishing the presence of the community physician, but it is far from clear how significant this new role is going to be. It seems likely that eventually the weak collaborative machinery between health and social services will have to be strengthened and the Family Practitioner Service linked more effectively with the rest of the health and social services. Thus, some elements in the structure may be called into question as circumstances develop in such a way as to make some of the apparent achievements of the medical profession irrelevant and to hasten a new re-organisation. It may also be significant that although the medical profession has been fairly rigorously excluded from local authority social services, local government has been accorded representation in the management of the NHS at area level even though this creates some degree of confusion about the role of these representatives. It is also likely

that there will be de facto local government representation at regional level. Above all, both political parties are publicly on record as recognising that the logical long-term solution is to put the administration of the NHS into the local government structure. In any future re-organisation of the NHS this may prove to be a powerful starting-point.

CHAPTER VIII

Conclusion

It is possible to come to some judgements about first, the origins and timing of the re-organisation of the NHS, and second, the contribution made to re-organisation by the various bodies involved.

Although the publication of the Porritt Report had thawed the post-Guillebaud freeze on significant discussion of re-organisation of the NHS structure, neither the advent of a new Minister of Health, Kenneth Robinson, in 1964, nor the prospect of local government re-organisation awakened by Richard Crossman in 1965, necessarily meant that the administration of the NHS would be made to undergo drastic changes. Far greater significance may be attached to the development of the concept of community care with its implications for the development of the local social services in collaboration with the health services at the same time as social work was seeking to establish its professional status and free itself from medical domination. These developments found expression in the Seebohm Report of 1967, which saw the future of local authority personal social services in terms of a division between medical and social work skills, and this gave rise to the political problem of the future responsibilities and location of medical officers of health, who had to be transferred to the NHS.

The implementation of the Seebohm Report necessitated a transfer of local authority health services to the NHS and hence transferred a demand on the resources of local government budgets to the central government budget, and

thus opened up wider questions than just those of lateral co-operation between the different agencies concerned. At the informal meeting between the Minister of Health and members of the Seebohm Committee in February, 1967, he was made aware of the implications of the probable recommendations of the Seebohm Committee, and that the re-organisation of the local authority social services would pose questions relating to structural adjustments of the health and social services and central administrative supervision of the services.

Effectively, therefore, there were two aspects to the subsequent re-organisation of the NHS. The first, and most important from the viewpoint of central government, was the question of vertical control of the NHS, largely settled between the DHSS and the Treasury. Both had a vested interest in ensuring greater central control of the NHS. The DHSS wanted to be able to steer policy more effectively from the centre whilst the Treasury wanted to ensure a greater degree of management accountability in its search for improved control over social service budgets. Second, there was the search for increased lateral co-ordination and co-operation between the three branches of the NHS, and also between the NHS and local authority social services.

Basically, there were four possible solutions to the problem of establishing a new structure. First, health and social services could have been brought together in a new ad hoc structure, possibly a public corporation. This was ruled out on the grounds that the objections of Parliament

would have been too strong. The Porritt Report had also rejected such an approach from the medical profession's side. Second, social services could have been placed under medical officers of health and co-ordinated with the NHS through them, as the Society of Medical Officers of Health and the BMA argued to the Seebohm Committee. This solution was rendered impossible by the recommendations of the Seebohm Committee and their implementation. Third, the NHS could have been brought under local authority control alongside the social services. This was resolutely opposed by the Treasury and the medical profession. Fourth, the two services could remain within separate revised structures, and be co-ordinated at those points where "inter-face" was considered necessary. This was the solution which was adopted.

The first Green Paper was largely determined in negotiations between the Ministry of Health and the Treasury. Criticism directed at the first Green Paper, particularly at its managerial aspect, its one-tier structure, and its lack of any element of democracy or consumer representation, coupled with revised expectations about the likely shape of local government reform and the need to adjust radical reform of the NHS to political realities led to a shift away from the ideas of the first Green Paper. With a new Secretary of State at the amalgamated DHSS, the second Green Paper contained notions about the representational as well as the managerial character of a new NHS structure. Nevertheless, in its attempt to find a compromise which would meet the ambitions of the relevant interests to the greatest

possible extent, the second Green Paper abandoned the fundamental changes suggested in the first Green Paper, and recognisably retained much of the existing structure.

In the event, the new Secretary of State in the Conservative Government of 1970 was able to trade extra resources for the chronic sector of medicine for the improved managerial system desired by the Treasury which had been concerned about the lack of effective management from the centre in the health services of the post-Fulton era. It was the provisions for a strong vertical line of control from the Secretary of State through regional and area health authorities which were made by statute, and from which the Secretary of State refused to budge. Here, the pressure groups in local government and medicine were able to play only a minor part. The consultants in the medical profession pressed strongly to be contracted at regional level, as they were in the previous structure, rather than at area level with its local government connections, and this may have been a contributory reason for the retention of the regional tier, although this was also wanted by civil servants at the DHSS for liaison purposes and as a "buffer zone". However, when taken in conjunction with the area tier established for purposes of co-ordination with local government, arguably one tier or the other is superfluous. Medical advisory committees were also established at all levels by statute, as were the family practitioner committees linked to area health authorities, which were virtually the old executive councils re-incarnated. Neither of these points essentially affected

the vertical structure. Local government pressure may have played some part to the statutory position of community health councils, where opinion expressed in the White Paper debate in Parliament forced Sir Keith Joseph to re-think the position.

The pressure groups were able to play a larger role in questions relating to lateral organisation and co-operation, which ostensibly were the public reasons for the re-organisation. Here, the medical profession successfully resisted integration into the local government structure, whereas local government lost its remaining health services to the new NHS structure, although paradoxically, both political parties would have preferred such an integration although they had to recognise it would not be accepted by the medical profession. The medical profession was also successful in obtaining the transfer of the school health service to the NHS in spite of vigorous local government opposition. When these achievements are added to those already noted in relation to consultant contracts, professional advisory committees and family practitioner committees, together with the special provisions made for area health authorities with teaching hospitals, then the medical profession can indeed be said to have successfully maintained its position. Nor was this all. Under the management arrangements worked out under the DHSS steering committee and implemented by regulation, the medical profession was accorded a virtual veto over plans made at District Management Team level where consensus decisions were to be the rule and both consultants and general

practitioners were to have elected representatives. The medical profession was also to be powerfully represented in the Health Care Planning Teams at district level, and in the Joint Consultative Committees charged with fostering collaboration with the co-terminous local authorities.

By contrast, local government, with all the logic of its available administrative structure and skills, seemed to fare badly. It was opposed by the Treasury, by the medical profession and by influential people in the Ministry of Health and the DHSS. It lost its remaining health services, including the important school health service, was denied statutory representation on regional health authorities and was given only minority representation on area health authorities and on the community health councils, whose functions it had hoped to perform.

It may be argued then that although the pressure groups played a lesser part in the re-organisation than they did in Willcock's account of the creation of the NHS, in terms of achievement the same pattern emerges, with the medical profession, with its command over the necessary technical skills gaining more than local government with its administrative structure and skills. Nevertheless, local government could point to the future with more hope. It had gained a public admission of the logic of its case and the desirability of the future integration of the NHS into the local government structure by both political parties. The possibility of adjustment of the membership of area health authorities by regulation meant that local authorities could be given more recognition at this level

by a minister with more sympathy for their case. This occurred in 1975, when Mrs. Castle raised the number of local authority representatives on area health authorities to six out of 16, as a result of the paper "Democracy in the National Health Service". This may be an omen for the future. Command over resources in the shape of professional skills may have given the medical profession its victories in this re-organisation. A future re-organisation may take more account of economies in public expenditure to be found in co-ordinating health and social services in one structure, and reason may take account of the available administrative structure in local government.

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